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Comunicación: Exploring Language and Cultural Barriers in Healthcare

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COMUNICACIÓN:
EXPLORING
LANGUAGE AND CULTURAL BARRIERS
IN
HEALTHCARE

An Honors Thesis

Presented by

Jessica Sarah Bayner

To

The Department of Self-Designed Interdisciplinary Major

Honors in the Major Field

Multicultural Medicine and Communication
Concentration: Hispanic Society

May 2007

Prepared under the Direction of

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שלום

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PROLOGUE

“Hola, me llamo Jessica. Vivo en Nueva York. ¿Cómo estás?” The endless times I repeated these simple sentences in my Spanish classes made me question when I was actually going to put vocabulary lists to use. The opportunity finally came when I was given the chance to do an in-depth study of a topic of my choice. To combine my interest in Spanish and medicine, I decided to explore bilingualism in healthcare. My passion arose from personal experiences in which I had to translate for non-English speakers in clinical settings. My interactions with those that were unable to clarify their needs and concerns made me want to use my resources to be of some assistance. Talking to physicians, psychologists, lawyers and activists enhanced my understanding of the subject as a whole. By being exposed to various perspectives on communication between Spanish-speaking patients and healthcare professionals, I was able to engage in dialogues and reflect on different aspects of the issue.

The ability to relay an idea or message to another is extremely powerful, as it requires coherence on the part of the communicator, and understanding on the part of the person one is communicating with. In terms of healthcare, a patient’s needs must be made clear to the Doctor. Likewise, a Doctor should be able to convey his/her thoughts to whomever is being treated. However, the success of such an interaction with Hispanics in particular is not only based on verbal efforts; body language, culture, and signs of respect all come into play (de Paula, Lagana, & Gonzalez-Ramirez 203, as cited by Kemp). Unfortunately, as a result of language barriers and a lack of familiarity with different customs, many Spanish-speaking patients are unable to obtain the optimal level of care

from Doctors who are non-native speakers. This leads to an impersonal setting, and makes Hispanics dissatisfied with the care they receive (Kemp 2003).

In accordance with Title VI of the Civil Rights Act of 1964, translators must be made available to non-English speaking patients in healthcare settings. Even though this is a mandate set by the federal government, there remains to be a shortage of such services. This leads to complications concerning patients undergoing medical treatment. With an understaffed facility, desperate attempts are made to find anyone who can relay the symptoms/problems of those in need of assistance. Many times strangers are asked to interpret between patients and healthcare workers, along with relatives and children of patients (Dix 2005). In fact, I have been witness to such circumstances while volunteering in an Emergency Department in New York City. There were several instances in which the staff had to look up their database of interpreters in order to understand the needs of patients in the ED. The epilogue describes an experience I had where I was asked to serve as a translator for a patient although I was not registered as a worker for the hospital. Especially because this occurred in a Department where quick and efficient treatment needs to be provided, I was concerned about the situation on a micro- and macroscale. Bilingualism would enable healthcare professionals to better understand those ask for care. Considering the diverse United States population, one that is a mix of various cultures, ethnicities and languages, communication is even more of a issue in today's society.

Aside from working in the hospital, I was fortunate to study in Mexico during the summer between my junior and senior years at Connecticut College. In Jalisco I attended La Universidad Autónoma de Guadalajara as a student in the Spanish Medical Course.

My colleagues and I learned about medical terminology in Spanish, had direct contact with patients in local clinics, and studied various health issues that concerned the regional patient population. After the program ended in July, I went to intern at J.R. Medical in Bay Shore, Long Island. In terms of facilities and location, the New York site was clearly different from the places where I worked in Mexico. However, the clientele was very familiar; predominantly Hispanic, Spanish-speaking patients. My discussions with the Mexicans I met in outpatient clinics in Guadalajara foreshadowed the conversations I would have with clients in New York, and together both experiences gave me insight to issues facing Hispanic immigrants.

From the start of the academic year, I continued to study bilingualism in healthcare as a Psychiatric Intern at the Community Health Center in New London, CT. I translated for patients who would have otherwise been unable to have therapy sessions, and I worked to enhance medical communications -- this time with the Hispanic community of New London, CT. This experience has shown me that from lack of medical care to language barriers, people from both sides of the border work through similar struggles. Thus, I have come to see how international issues connect with national ones, and how by confronting the issues our own communities face, we can also affect communities of the world.

The surveys and interviews that I conducted with people internationally gave me insight on concerns in medicine, particularly among Spanish-speaking patients. This made me determined to share what I had learned about the matter, in the hopes that I could spread awareness and possibly motivate others to become dedicated to the issue at hand. The best way to do that, I thought, would be to incorporate the stories I had heard into

my project. In addition to adding a creative writing component to the work, I considered it a way of giving a platform to those patients who had expressed frustration in being unable to do so in the past.

As reading and writing have always been tools of reflection for me, I wanted to express myself and also try to imagine the efforts expended by those patients who were unable to communicate themselves. The stories that introduce the chapters are thus not only a way to foreshadow the proceeding analyses, but they are also a composite of what I have heard and seen. My efforts to translate the stories in Spanish are an exercise in making information accessible to the population being addressed throughout the whole project. Even though I knew what I had to say, and had the means to express myself, getting all of my thoughts across in a different language was quite difficult. As a non-native Spanish speaker, I found myself getting frustrated at being unable to decipher completely everything that was first written in English. I found myself turning to others to translate for me as I have done for others whose ideas and experiences exceed their ability to communicate. My efforts, however, only account for a fraction of what non-English speakers encounter. Writing under the pressure of a deadline can be an arduous task, but to be a patient faced with a problematic, time-sensitive situation without resources is quite another. The decision to only translate the stories and not the analyses is also symbolic of the consequences of language barriers; even when bilingual services are provided, those who do not speak the language of choice get excluded in some shape or form.

In an effort to take what I had learned and apply it locally, I considered implementing bilingual informational sessions in the New London Community Health

Center. Specifically, I wanted to discuss different aspects of medicine as a way of giving access to healthcare to Spanish-speaking patients. This proved to be a challenge, upon discovering the logistical difficulties that the process entailed. However, a suggestion from a classmate led me to create a DVD done in Spanish and English, which would accomplish my original goal and inform both patients and healthcare professionals. Since the nature of the work was interdisciplinary to begin with, using narrative pieces along with policy analyses and an informational DVD seemed appropriate. The DVD created for this particular center addresses vocabulary and phrases specific to the site, such as what one might encounter at the front desk, with the dentist, in mental health and while given instructions for medications. The DVD serves as a model of what can be implemented in health facilities that face language barriers.

Proper communication is the key to understanding others -- not only at a transparent level, but in a way that allows for people to acknowledge and realize the differences between races, genders, classes, etc. An optimistic result of my work would be for my efforts to be continued, making communication a priority in healthcare. In the very least, I have certainly learned about the situation a whole and I am grateful for everyone who taught me so much along the way. The exchange of ideas, thoughts, and issues is a dynamic process, something which I trust is communicated throughout this work.

INTRODUCTION

Melting Pot. Land of Opportunity. The American dream. Such terms are often applied to the United States, but after close inspection, they can be seen as misnomers. To what extent do different peoples really interact with one another and work to create an integrated society? While America offers the chance for prosperity, how many immigrants travel from their native lands, only to struggle and live in poverty? And although the country has economic and political influence on a global scale, what does it do to address the internal conflicts that prevail on its own soil?

Such questions invariably arise when critiquing a diverse nation. The United States is home to various races, religions, languages and ethnicities that coexist within its borders. Consequently, Americans have greater exposure to people of different minority backgrounds who have made an effort to preserve their traditions and customs. Thus, the analogy of the country as a pluralistic salad bowl has prevailed over the assimilationist theory of the melting pot. As a result, even though these different structures of identity have been exposed to one another, a true understanding of the respective cultures has not been reached.

One of the main reasons for this disconnect is the language barrier that exists between numerous homogenous societies that attempt to communicate with each other. Although the majority of the country's populations are able to speak English, there are many "language communities" that continue to speak in a language other than English (Romaine 386). The lack of a common language, therefore, would logically seem to prevent these groups of people from assuring the development of a cohesive society.

The communication issue, however, does not just cause a problem in the realm of integrating and creating more understanding amongst peoples. The healthcare industry has also become affected, in reference to patients with limited English proficiency. Such populations have difficulty clearly relaying their needs and concerns to healthcare providers that are not familiar with their language or culture (Marcos and Trujillo 193). This presents an obvious obstacle for language minorities trying to receive quality medical treatment, and as a result, policies have been enacted for the sake of remedying this situation.

The progress that has been made to allow for patients to communicate in their preferred language is certainly commendable. However, there still remains a shortage of translators, employed bilingual staff members who are not trained to act as interpreters, and language hotlines that are used but are not the most conducive means to conduct therapy (Duzant, interview). Some argue that this calls for more programs to be implemented in order to suit the needs of non-English-speaking patients. Others disagree and place more responsibility on the client who wishes to get treated. In the meantime, the root cause of the problem is ignored, as issues concerning policies in healthcare continue to be debated. This leads to the inevitable question that will serve as the focus of this study: What are the concerns of medical providers in a language community?

Specifically, my focus will deal with two healthcare settings and the way in which they cater to Spanish-speaking patients. J.R. Medical a private practice located in Bay Shore, NY and The Community Health Center in New London, CT will be used to evaluate the level of satisfaction felt by clients. These sites deal with predominantly Spanish-speaking patients, as the 2000 U.S. Census Bureau indicates that Hispanics make

up 19.7% of city of New London, and 19.9% of Bay Shore, NY. Such a percentage calls for programs and initiatives to be made in order to adhere to mandates that were created to ensure quality medical treatment in racially and linguistically diverse areas.

The earliest and most significant piece of legislation dealing with the disadvantages that minorities -- including language minorities -- face is Title VI of Civil Rights 1964 Act:

No person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

In accordance with Title VI, the Department of Health and Human Services (HHS) released information to clarify the rights of patients under the 1964 Act. Examples of programs and/or institutions that are applicable include extended care facilities, hospitals, community mental health centers, family health centers and clinics, State and local public assistance agencies and nutrition programs. Furthermore, HHS made pamphlets about the “Responsibilities as a Health Care Social Service Administrator” to ensure that medical service is given equitably to people, regardless of their backgrounds. Not providing a Spanish-English translator, for example, in a region where there is a large Spanish-speaking population (at least 10%), is considered discriminatory treatment.

The implementation of Title VI revealed an awareness about discriminatory Federal programs and a desire to confront related issues. However, the action taken to ensure equal rights and inclusion for those that still faced prejudice left something to be desired. Little to no steps were taken in regards to reviewing healthcare systems to see if

they complied with Title VI. Any reform that was made focused on accessibility of healthcare in underserved areas, but did not address actual communication issues between patients and physicians (Appropriations, Part 7).

In response to the lack of effort made to create actual change, a demand was made for progress and programs that responded to the needs of minority populations. For example, feelings of dissatisfaction with medical care led concerned Puerto Rican in New York City to form The Young Lords Organization in 1969 (Morales, interview). Aside from voicing alarm about matters of political injustice, the Young Lords worked to address access to healthcare amongst the Hispanic populations. The Health Revolutionary Unity Movement was later created, as a combined effort between the Young Lords and the Black Panthers to fight for healthcare rights of blacks and Hispanics in New York.

With regards to recent progress, the Office of Minority Health (OMH) of HHS released an Executive Summary in March of 2001 concerning the standards to be met for minorities seeking medical assistance. “The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care” includes mandates, guidelines and recommendations for programs that receive Federal funds. The mandates are standards 4-7, which are required to be met; they all concern the necessity of offering language assistant services and/or written materials in the language of the patient.

In order to move forward in an effort to actually address the root of the issue, however, one must address the various factors that might lead Hispanics to remain segregated from the rest of their communities. Learning a foreign language is no simple task, especially under the pressures of financial and familial responsibilities. Being bilingual is often a consequence of privilege, with the resources and support that allow

one to pursue an education (De Avila and Duncan 337). Thus, Spanish-speaking immigrants who face the obstacles of immersion -- which include ascending the socioeconomic ladder -- very often can not afford to devote time to learn English, leaving future generations to immerse themselves and act as translators for their families.

Still, there are those who say that there is no excuse; immigrants who live in America have the opportunity to be exposed to English. Although there is no national language, it is certainly the most prevalent, especially with relation to healthcare facilities and amongst Doctors in the United States. Moreover, many argue about the potential future of programs that are created in order to accommodate the felt needs of patients. What will be the breaking point of such reform? Will physicians be required to learn a foreign language as part of their medical training? What is to prevent medical schools from including proficiency in Spanish as part of their standards for acceptance?

In addressing a policy's impact in general, the Wallen "stages of problem solving" can be used as a guide (Lynch 9). In this case, the first step of the problem has been identified. There has been a felt need: to oblige the population of a given area when healthcare comes into question. A subsequent step has also been taken, as proposals and mandates have been made to resolve the problem. Part of the final stage of analyzing the policy is determining its success in relation to the goals it aimed to achieve from the beginning. Indicators to help determine the efficacy of the policy include testimonies from patients regarding their personal satisfaction with the healthcare they receive. Moreover, the thoughts of the medical providers themselves provide important insight as to how policies affect those who need to comply with them. Thus, this study will take

into account both sides of the argument concerning medically-related bilingual policies as a way to analyze the situation and possible outcomes.

The first chapter reveals the efficacy of programs made to accommodate Spanish-speaking patients in their desire to obtain adequate and quality medical treatment in their preferred language. A short story will begin this chapter, from the point of view of a patient seeking psychological treatment, unable to properly relay her concerns. Mental Health was chosen as the context for the language barrier as it highlights the implications of being unable to communicate, particularly within a branch of medicine that relies heavily on the ability to express oneself. The English and Spanish versions of the narrative will be followed by data gathered from surveys with results that have been tabulated using the statistical computer program SPSS. The analysis will also include insight taken from interviews conducted with the native Spanish-speaking patients in New York and Connecticut.

The second chapter opens with the same story as the first chapter, but from the perspective of the medical provider who is unable to communicate with the non-English-speaking patient. It has also been translated into Spanish. Given that the story is told from the point of view of a provider who does not speak Spanish, readers are to keep in mind that the Doctor is thinking in English. Furthermore, one can differentiate when English is spoken by taking note of the phrases put in bold font. In addition to the same surveys from the previous chapter, interviews and research regarding the standpoint of healthcare professionals who work with Spanish-speaking patients will be discussed in the chapter.

Preceding the analysis portion of the third chapter, there will be a story told through the voice of the researcher, who was faced with the responsibility of acting as an

interpreter in a hospital. As with the other narratives, it will be followed by a Spanish version. Furthermore, a script for the enclosed DVD addresses vocabulary and expressions determined to be appropriate for The Community Health Center in New London, with the intention of using it in the Center's waiting room. The DVD is meant to serve an example of ways to increase communication between Spanish-speaking patients and healthcare professionals.

The conclusion will provide a summary of the thesis and the subject matter tackled by each chapter. It will attempt to gauge the impact of language barriers have had between medical providers and their patients, with a specific focus on sites treating Spanish-speaking populations. Using the New York and Connecticut sites, the success of policies implemented to provide linguistically appropriate services in healthcare are considered. Effective communication will be discussed in terms of the satisfaction of patients in general and specialty branches of medicine. Thus, the overall themes concerning cultural and language barriers encountered by Spanish-speaking clients will be addressed.

CHAPTER ONE



CAPÍTULO UNO

WITH EFFORT

I sit upright on the hard chair, in the office with diplomas and pictures that hang on every wall. This is my first session with the therapist, and I anxiously wait to meet him after his having been being paged on the intercom to go to the front desk. I had thought about making an appointment for six months now, but always found an excuse to avoid doing it. The afternoon sunshine lights up the room through the large windows behind me. Although half a day has gone by already, all I can remember are the papers that were given to me when I first arrived. Sheets upon sheets upon sheets of lines and boxes to be filled and checked with my personal information. Name: Maria Luisa Guerrero. Race: Hispanic. Preferred Language: Spanish.

My mind wanders and I start to become preoccupied with thoughts of my family. I can imagine my daughter playing in the waiting room with the toys she brought from home. My husband Miguel is probably sitting by her side, his wrist occasionally in the clutch of her five-year-old hand. I picture my son watching the basketball game in silence, along with the other family members and friends of patients. They are safe, I know, but I still worry because I know they are concerned for me.

I begin to wonder how much they actually know about my problem. My exhaustion can be attributed to a simple lack of sleep, but even I don't understand the root of it all. My bouts of insomnia, my phases of high energy – I've been feeling out of control for many years now, but never thought to seek help for it. As a wife, a mother of two, and a provider for my family, I never really had the time to reflect on my state of mind. But when the hallucinations started, I knew I had to seek professional help. The

voices, the people that only I could see terrified me. Now I just hope I can relay all this to the psychologist.

~ * ~

After moving to the States with Miguel, we married and settled in New York. I had some family that lived in the city who had started a restaurant business, and helped us get financially established. Miguel worked as an accountant and I was hired as a hostess. We've stayed at "El Centro" as it has expanded, but now Miguel also drives a taxicab during the nightshift so that we can pay for our children to attend Catholic school.

I've grown accustomed to our lifestyle, but I can tell Miguel is unhappy with the way things have turned out. He earned a degree in engineering, and had hoped to work in the field in our hometown. I had planned on becoming a nurse, and was employed at my local hospital in Mexico. However, we both decided to start a life in America, so that our future children could have more opportunities to grow and broaden their horizons. Still, I sometimes get overwhelmed with the guilt that I never lived up to my abilities. I'm sure Miguel also feels resentment with each tip that he earns, knowing that his customers probably devalue his intelligence and potential.

I suppose it all comes down to language. I've lived in this country for fifteen years, and I still feel uncomfortable with my English. Growing up in Mexico, I studied English in grade school, but I soon forgot whatever I had learned after I graduated. The reason we couldn't apply to jobs outside of "El Centro" is that we didn't speak English. Our family helped us get situated, so we only became exposed to the common, essential English words that were useful in our daily life. Even if we were interested in becoming more proficient, we were related to everyone in the restaurant, and they all spoke

Spanish, so it was difficult to practice English. We said that we could learn along with our children as they grew up, but they became used to speaking Spanish inside the home and reserving English for school.

I usually don't think about my shortcomings with English. I can ignore stares, pretend not to hear whispers, and dismiss comments that are made when Americans get frustrated that I don't speak "their" language. But why is there no expectation to learn mine? And there *is* no national language -- Spanish is widely spoken throughout the country and the world, so what makes English the language by default? Besides, this nation was founded on the work and growth of immigrants. Making us feel like outcasts who need to conform to an unspoken standard certainly does not embody the American dream.

But those instances in which I truly wish to express myself.... that is when I feel incompetent. It is not just that I am unable get my point across. My education and prior experience working with people made me feel useful and valuable. I contributed to my community. I got energy from interacting with others, and learned a lot from patients I assisted as a nurse-in-training. My limited English vocabulary is not a fair reflection of my thoughts. It pains me a bit to know that the people I talk to in English most likely underestimate the complexity of what I mean to say. This also does not make me eager to speak in English; my fears of rejection and looking foolish make me feel uncomfortable to make such an effort.

~ * ~

The office door swings open and the therapist walks in. He introduces himself as Dr. Seoh. I briefly glance at his degree in Psychology to see his full name: Nathan

Eugene Seoh. I laugh out loud for a moment after realizing that his first two initials and last name sound like *necio*, which means silly in Spanish. *Dr. Silly*, I think to myself, as I laugh out loud. But then I bring my focus back to Dr. Seoh, who does not look amused, but rather critical of my behavior. I couldn't explain to him what had just happened, so I decided to try to initiate any other conversation.

"I do not speak English much," I manage to get out. "Thank you for the time."

Dr. Seoh politely nods and closes the door, after which point he sits down in the leather chair next to it. He begins to talk to me, and from his hand gestures and the words that I recognize, I gather that he does not speak a lot of Spanish. However, I can tell that he wants to try and work through the session, proceeding to pull out a folder that had all of the paper I filled out earlier.

With my previous experience at the hospital, I was familiar with the sort of questions that he was going to ask in order to have an accurate record of my medical background. Due to this, and Dr. Seoh's knowledge of some key words in Spanish, the first page of the evaluation is not problematic. I know how to say that I am married and that I have a boy and a girl. I want very much to describe them, but I cannot do them justice in English. Instead, I take out my wallet and show Dr. Seoh the many pictures that I have of my family. He smiles and says, "Very nice, pretty children. Beautiful." I point to the photos that stand on his desk, in mahogany frames. "You?" I ask. Dr. Seoh follows my finger and turns around to see what I am referring to. "Yes," he answers, "Those are my kids. Twelve and four years old." I look all the smiling faces captured on film, with a longing to be able to talk to him about the trouble and joy that families bring, and connect with him on a personal level. But I cannot. So I sit back and wait for the next question.

“So, Mrs. Guerrero, why are you here today?” he continues.

“I have problem with sleep but I see people too.”

“So you’ve consulted a physician regarding this issue?”

With hesitation, I answer, “Emm, I do not understand.”

“Umm....”After pausing for a moment, Dr. Seoh tries again, in a slower speed.

“Did you see someone before about your sleep problem?”

“No, nobody from before. You the first person I go to.”

“Hmmm, alright,” Dr. Seoh notes in the file. “But you see people?”

“Yes, yes,” I say as I touch my temples with both hands.

“Do you think they are hallucinations?”

“Halll-uu-ceee-nnayy-shheoo-ns?” I repeat, in an effort to get it right. I go over it in my mind and think in Spanish for a word that might explain who these people are.

“Ah, Sí, hallucinaciones. I think so, Doctor.”

Dr. Seoh looks at me, points to his eyes and asks, “Do you see anything more?”

“More?” Well, there are the shadows. Sometimes the people are not there, but their shadows will become visible and then disappear, as if they are hiding and then running away. But I did not know the word for “shadow” in English. I reply by shrugging my shoulders and say “Sombras,” in the hopes that he will know the word.

“Sombras?” responds Dr Seoh.

“Sí, yes, Doctor.” I point to the floor and move my hand across it to try to convey what I mean.

“No entiendo, Maria,” the Doctor says. “Maybe...Can you show me how these people make you feel?” He pats his chest, over his heart.

I want to explain that I am the only one who knows that these people exist. I want to tell him how scared I get when they come to me, since I am unable to control when they appear. I want to tell him that they have started talking to me now. I want to tell him the reason I decided to make an appointment, was that when I tried to ask them to leave me alone, my little girl heard me. I want him to tell me why this is happening, and how to stop it. Yet all he does is shake my head and tell him, "People everywhere. I don't understand, but I now I hear speaking."

"Speaking? You hear voices?"

"Voices now. Sometimes I hear but I say to go because I'm scared."

"What do the voices say, Maria?" Dr. Seoh asks me.

Looking into Dr. Seoh's eyes, I can feel an added level of intensity that differs from the way he presented the other questions. Going over the recent interactions I have had with the hallucinations, I realize that they never really said anything substantial. Only a few words, or sentences that remind me of any tasks that I have during the day. I do not want to worry the Doctor, but I cannot tell him the details of the conversations I have had. With the fear that I would seem crazy, I decide not to attempt to verbalize my thoughts and that the best answer I can give him is "Nothing, Doctor." I protest with my hand, gesturing that there is no reason to be concerned. "No worry, is nothing."

Dr. Seoh tilts his head with a look of suspicion. "It's not nothing, Maria. If you hear voices, I need to know what they say to you. I know it's hard to communicate, but we have to talk about this. I'm going to call the language hotline."

I watch as he opens a book next to his telephone and dials a number. He waits for a moment and then begins talking to someone on the other line. I hear him say "Spanish"

and now I recognize the word “hallucinations.” A few minutes later, Dr. Seoh pushes a button and motions for me to talk. “Está bien,” he assures me. “Please – tell the woman on the phone.”

“Hello?” I say into the telephone. It is difficult to hear the other line, so I am forced to move my chair and sit next to the Doctor in order to converse. “Hello?”

“Si, Señora Guerrero. Me llamo Nancy y ahora puede comunicarse conmigo en español. ¿Esta gente – que exactamente es lo que le está diciendo?”

I sigh in relief and explain the voices to the woman on the phone, along with the shadows that I occasionally see. Dr. Seoh seems a little more relaxed, and moves along the questionnaire. We continue the rest of the evaluations going back and forth between the Doctor, Nancy and myself in English and in Spanish. I do not get to elaborate on my feelings, because the whole process is so time consuming, but we begin to talk about plans for our next session.

Before discussing the actual appointment date, the Doctor has Nancy let me know about my options for further treatment. Since I am not proficient in English and he is not fluent in Spanish, he thinks it would be impossible to treat me by himself. I could have him as my therapist, but with the provision that the hotline be used in order to make a fair assessment of whatever I said. I could also ask to be put on the waiting list for the Spanish-speaking psychologist that was available, but I would have to wait at least a month until she had any opening slots. There was also the option to get a referral to another center which had more bilingual staff.

Without any sense of what to do, I turn to Dr. Seoh and told Nancy to ask his advice. I watch as he answers, revealing a genuine interest in the matter. She tells me that

he cannot decide for me, but that I should be in the most comfortable position possible if I want to get better. I choose to wait for the therapist who speaks Spanish. It was difficult to be uninhibited while talking into a speakerphone and the other center was half an hour away. I look at Dr. Seoh, who nods in understanding, and has Nancy tell me that we can go to the front desk now to arrange for me to be put on the list.

He hangs up the phone and sighs. We smile at one another, and after a few minutes I put my chair back to its original place in front of the windows. I notice that the sun has gone down since I first felt its warmth, shining through the office while I waited for Dr. Seoh. The office was still lit by the fluorescent lamps that were on, but it seemed much darker to me than before. I gather my belongings and walk with the Doctor to the waiting room, where I introduce him to my family. He meets Miguel and my children, after which point he turns to me and says, “Mucho gusto, Maria. Gracias.” I shake his hand and reply: “Gracias a Usted, Doctor. Thank you very much.”

CON ESFUERZO

Sentada derecha a la silla dura en la oficina, veo títulos y fotos colgadas en las paredes. Es mi primera sesión con el terapeuta, y lo espero ansiosamente para que aparezca después de haber llamado a la recepción. En los últimos seis meses he querido hacer una cita, pero siempre encontraba una excusa para evitar hacerlo. Detrás de mí, el sol de la tarde ilumina el cuarto por las ventanas grandes. Aunque se me haya pasado la mitad de un día, sólo puedo recordar los papeles que me acabaron entregar. Las hojas sobre hojas de líneas y cajas para ser llenadas y verificados con mi información personal. Nombre: Maria Luisa Guerrero. Raza: Hispano. El idioma preferido: español.

Mi mente vaga. Comienzo a preocuparme con pensamientos acerca de familia. Puedo imaginarme a mi hija en la sala de espera, jugando con los juguetes que ella trajo de casa. Probablemente mi esposo Miguel está sentado al lado de ella, su muñeca ocasionalmente agarrada por la mano de la niña. Tengo una visión de mi hijo, junto con otros parientes y amigos de pacientes, viendo el juego de baloncesto en el silencio. Sé que ellos están a salvo, pero me preocupo todavía porque sé que ellos se preocupan por mí.

Comienzo a preguntarme cuánto ellos saben sobre mi problema. Mi cansancio puede ser atribuido simplemente a una falta de sueño, pero hay más que me molesta. Mi lucha con el insomnio y mis momentos de alta energía -- me han hecho sentir fuera de control por muchos años, pero nunca pensé buscar ayuda. Como esposa, madre de dos, y proveedora para mi familia, nunca tuve el tiempo de analizar mi estado de ánimo. Pero cuando las ilusiones empezaron, supe que tenía que buscar ayuda profesional. Las voces

y la gente que sólo yo podía ver me aterricé. Ahora, simplemente deseo a contárselo al psicólogo.

~ * ~

Después de mudarme a los EE.UU. con Miguel, nos casamos y nos quedamos en Nueva York. Tenía alguna familia que vivió en la ciudad quien manejaba un restaurante, y nos ayudaron a establecernos financieramente. Miguel trabajó como un contable y me empleó como una anfitriona. Nos hemos seguido trabajando en “El Centro” mientras crecía. También, ahora Miguel conduce un taxi durante el turno nocturno, para que podamos pagar por la inscripción de nuestros niños a asistir a una escuela católica.

Estoy acostumbrada a nuestro modo de vida, pero puedo ver que Miguel no está satisfecho con la manera en que las cosas han resultado. El obtuvo un título en la ingeniería, y quiso conseguir un trabajo en esta carrera en nuestro pueblo de origen. Yo había planeado llegar a ser una enfermera, y trabaje en mi hospital local en México. Sin embargo, nosotros decidimos empezar una vida en América, para que nuestros hijos pudieran tener más oportunidades en la vida y amplían sus horizontes. Todavía, estoy agobiada a veces con el sentimiento de culpabilidad que nunca viví de acuerdo mi potencial. También estoy segura que Miguel siente el resentimiento con cada propina que él gana, sabiendo que sus clientes desvalorizan probablemente su inteligencia y capacidad.

Yo supongo que todo tiene que ver con el idioma. He vivido en este país por quince años, y me siento todavía incómoda con el inglés. Lo estudié en la primaria en México, pero en pronto me olvidó lo que había aprendido después que me gradué. La razón que no podríamos solicitar a trabajos fuera de “El Centro” es a causa de que no

hablamos inglés. Nuestra Camila nos ayudó a establecernos, así que sólo llegamos a estar expuestos a las palabras comunes y esenciales del inglés que fueron útiles en nuestra vida cotidiana. Aún si estuviéramos interesados llegar a ser más capaz, todos del restaurante son nuestros parientes y hablan español, así que fue difícil practicar inglés. Dijimos que podríamos aprender juntos con nuestros niños mientras crecían, pero se acostumbraron a hablar español dentro del hogar, e el inglés en la escuela.

Yo no suelo pensar de mis problemas en inglés. Puedo no hacer caso de las miradas fijas, fingir para no oír los cuchicheos, y despedir los comentarios que son hechos de los americanos que se frustran porque yo no hablo “su” idioma. ¿Pero, por qué no hay una esperanza de aprender el mió? No hay un idioma nacional e el español es hablado extensamente por el país y por el mundo. ¿Entonces por qué el inglés es la lengua que todos deben saber? Además, esta nación fue fundada con el trabajo y el crecimiento de los inmigrantes. Hacernos sentir como parias que necesitan conformarse a un estándar tácito, esto ciertamente no personifica el sueño Americano.

Pero esos casos son en los que quisiera sinceramente expresarme... ahí es cuando me siento incompetente. No es apenas que no pueda decir algo en particular. Mi educación y experiencia trabajando con personas me hizo sentir útil y valiosa. Contribuí a mi comunidad. Me daba fuerzas el interactuar con otros y aprendí mucho de los pacientes que ayudé cuando era enfermera bajo entrenamiento. Mis limitaciones con el inglés no me permiten contar un reflejo justo de mis pensamientos. Me aflige un poco saber que la gente con la que hablo en inglés probablemente subestima la complejidad de lo que digo. Esto también no me motiva a hablar en el idioma; mi miedo al rechazo y a parecer tonta me hacen incómoda para esforzarme hablar en el inglés.

~ * ~

La puerta de la oficina se abre y el terapeuta entra. Él se presenta como Dr. Seoh. Miro brevemente su título en Psicología para ver su nombre completo: Nathan Eugene Seoh. Entonces yo pongo juntos sus primeras dos iniciales con su apellido: N.E.Seoh. Suena como necio, la otra palabra para tonto. Dr. Tonto, me pongo a pensar, mientras yo me río en voz alta. Pero después vuelvo mi atención a Dr. Seoh, que no parece divertido, sino crítico de mi conducta. No podría explicar a él lo que acabó de suceder, así que decidí tratar de iniciar otra conversación.

“I do not speak English much,” logro decir. “Thank you for the time.”

Dr. Seoh asiente cortésmente y cierra la puerta, después de que él se sienta en una silla de cuero. Él comienza a hablar conmigo y con sus gestos de mano y las palabras que reconozco, comprendo que él no habla mucho de español. Sin embargo, puedo ver que él quiere tratar y persistir con la sesión, avanzando a sacar un archivo que tiene todo los papeles que he llenado más temprano.

Por mi experiencia previa en el hospital, sé el tipo de preguntas que él me va a preguntar, para tener un registro exacto de mi fondo médico. Debido a esto, y el conocimiento de Dr. Seoh de algunas palabras claves en español, la primera página de la evaluación no es problemática. Yo sé cómo decir que soy casada y que tengo un hijo y una hija. Quisiera describirlos tanto, pero no lo puedo expresarme como quisiera en inglés. En vez de eso, saco mi cartera y muestro al Dr. Seoh los muchos retratos que tengo de mi familia. Él sonríe y dice, “Very nice, pretty children. Beautiful.” Señalo las fotos que están en su escritorio, en marcos de caoba. “You?” yo pregunto. Dr. Seoh sigue el dedo para ver a lo que yo me refirió. “Yes” responde, “These are my children. Twelve

and four years old. Miro todas las caras sonrientes capturadas en las fotos, con un deseo para poder hablar con él sobre los problemas y la alegría que las familias traen, y conectar con él a un nivel personal. Pero no puedo. Entonces yo me pongo cómoda y espero la próxima pregunta.

“So, Mrs. Guerrero, why are you here today?” él continúa.

“I have problem with sleep but I see people too.”

“So you’ve consulted a physician regarding this issue?”

Sin vacilación, continúo, “Emm, I do not understand.”

“Umm....” Después de detener por un momento, Dr. Seoh trata otra vez, en una velocidad más lenta. “Did you see someone before about your sleep problem?”

“No, nobody from before. You the first person I go to.”

“Hmmm, alright,” Dr. Seoh pone en el archivo. “But you see people?”

“Yes, yes,” digo mientras toco mi frente con ambas manos.

“Do you think they are hallucinations?”

“Halll-uu-ceee-nnayy-shheoo-ns?” repito, con la determinación de entenderlo bien. Lo repaso en mi mente e intento pensar en español sobre una palabra que quizás explique quién es esa gente. “Ah, Sí, alucinaciones. I think so, Doctor.”

El Dr. Seoh me mira, enséñala a sus ojos y me pregunta, “Do you see anything more?”

“More?” Pues, también aparecen las sombras. A veces las personas no están, pero sus sombras llegan a ser visible y de pronto desaparecen, como si ellos se escondan y entonces se escapan. Pero no sabía la palabra para “sombra” en inglés. Contesto encogiéndome de hombros y digo “sombras,” con la esperanza de que él sepa la palabra.

“Sombras?” contesta Dr. Seoh.

“Sí, yes, Doctor.” Señalo al piso y muevo mi mano sobre ello a tratar de mostrar lo que quiero decir.

“No entiendo, Maria,” dice el médico. “Maybe...Can you show me how these people make you feel?” Él toca su pecho, sobre su corazón.

Quiero explicar que soy la única que sabe que esta gente existe. Quiero decirle el grado de mi miedo cuando ellos me vienen, que no me puedo controlar cuando ellos aparecen. Quiero decirle que ellos han empezado a hablar conmigo ahora. Quiero decirle la razón por la cual decidí hacer una cita, que cuando intenté pedirles dejarme en paz, mi niña me oyó. Quiero que él me diga por qué esto sucede, y cómo pararlo. Mas todo lo que hago es asentir la cabeza y le digo, “People everywhere. I no understand, but I now I hear speaking.”

“Speaking? You hear voices?”

“Voices now. Sometimes I hear but I say to go because I scared.”

“What do the voices say, Maria?” Dr. Seoh me pregunta.

Al ver los ojos de Dr. Seoh, me doy cuenta de que él ha llegado a ser más tenso y cambió la manera en que presentó las otras preguntas. Repasando las interacciones recientes que he tenido con las alucinaciones, concluyo que ellos nunca dijeron realmente nada substancial. Sólo unas pocas palabras, o las frases que me recuerdan de cualquier tarea que tengo durante el día. No me gustaría preocupar al médico, pero no le puedo decir los detalles de las conversaciones que he tenido. Con el temor de parecer loca, decido no intentar expresar mis pensamientos. La mejor respuesta que lo puedo dar es

“Nothing, Doctor.” Protesto con mi mano, haciendo gestos que no hay razón frustrarle.
“No worry, is nothing.”

Dr. Seoh inclinó su cabeza con una mirada sospechosa. “It’s not nothing, María. If you hear voices, I need to know what they say to you. I know it’s hard to communicate, but we have to talk about this. I’m going to call the language hotline.”

Miro mientras él abre un libro al lado de su teléfono y llama un número. Él espera un momento y entonces comienza a hablar con alguien en la otra línea. Oigo que él dice “Spanish” y ahora reconozco la palabra “hallucinations.” Unos pocos minutos más tarde, Dr. Seoh empuja un botón y hacen movimientos para motivarme hablar. “Está bien,” él me asegura. “Please – tell the woman on the phone.”

“Hello?” Digo en el teléfono. Es difícil de oír la otra línea, de modo que soy forzada a mover mi silla y me siento al lado del médico para conversar. “Hello?”

“Si, Señora Guerrero. Me llamo Nancy y ahora puede comunicarse conmigo en español. ¿Esta gente – que exactamente es lo que le está diciendo?”

Suspiro aliviada; le explico las voces a la mujer por teléfono, junto con las sombras que veo ocasionalmente. Dr. Seoh parece un poco más relegado, y va por el cuestionario. Continuamos haciendo la evaluación entre el médico, Nancy, y yo en inglés e español. No tengo la oportunidad de elaborar sobre mis sentimientos, porque el proceso consume mucho tiempo. Pero comenzamos a hablar sobre planes para nuestra próxima sesión.

Antes de discutir la fecha de la cita, el médico le dijo a Nancy que me informa sobre mis opciones para el tratamiento. Como yo no tengo capaz de hablar inglés y él no habla español, él pensó que sería imposible a tratarme sólo. Podría tenerlo como mi

terapeuta, pero con la provisión que la línea directa es utilizada para hacer una evaluación justa de cualquier dije. También, podría pedir ser puesto en la lista de espera para la psicóloga Hispanohablante que estuvo disponible. Sin embargo, tendría que esperar por lo menos un mes hasta que ella tuviera una apertura. Además, podría pedir un referido a otro centro que tiene un personal bilingüe.

Sin cualquier sentido qué hacer, giro a Dr. Seoh y le digo a Nancy a preguntarlo su consejo. Miro mientras él responde, revelando un interés genuino en el asunto. Ella me dice que él no puede decidir por mí, pero que él piensa que debo estar en la posición más cómoda como posible si quiero mejorar mi condición. Escojo esperar para ver la terapeuta que habla español. Es difícil explicarme en el "speakerphone," y el otro centro está a media hora. Miro al Dr. Seoh, que asiento la cabeza con entendimiento, y le pregunta a Nancy decirme que ahora, podemos ir a la recepción para arreglar a ponerme en la lista de espera.

Él cuelga el teléfono y suspira. Sonreímos el uno al otro, después de unos pocos minutos yo pongo la silla en su lugar original delante de las ventanas. Noto que el sol ha bajado desde que me sentí su calor por primera vez, brillando por la oficina mientras esperé al Dr. Seoh. La oficina todavía es encendida por las lámparas fluorescentes, pero el cuarto me parece a mí mucho más oscuro que antes. Recojo mis pertenencias y ando con el médico a la sala de espera, donde le presento a mi Camila. Él se presenta a Miguel y a mis hijos, después él hacía mí y dice, "Mucho gusto, Maria. Gracias." Le doy la mano y respondo, "Gracias a Usted, Doctor. Thank you very much.

ANALYSIS

Maria Luisa Guerrero's story is but one example of the many Spanish-speakers who face language barriers in healthcare. The nature of a therapy session and the efforts involved in properly expressing oneself makes bilingual communication a unique concern in mental health, but similar issues arise in general medicine. In order to understand the different perspectives on this topic a variety of patients were asked about their experiences and opinions about communicating with their medical providers. Surveys and interviews were conducted with Hispanic patients in J.R. Medical, a private practice in Bay Shore, Long Island and The Community Health Center, a public clinic in New London, CT.

The survey was distributed to a group of 50 people, all of whom indicated Spanish as their first language. Women and men constituted 70% and 30% of the sample size, respectively. The ages of the participants ranged from 10-19 years to 80-89 years, with the majority falling in the 20-29 year group at 28%. The 40-49 year group at 20% was the next most frequent group. Puerto Rico was the most popular country of origin cited at 28%, followed by El Salvador at 22% and Colombia at 14%. Half of the participants indicated that they go to private practices for medical care, while the other half claimed to use public clinics. Data from J.R. Medical and The Community Health Center were collapsed together, as no statistically significant differences were found between the two groups.

Information collected from the surveys was analyzed using SPSS, a computer program widely used for data analysis. While statistical significance ($p < .05$) is addressed within the chapter, results have been evaluated more in terms of trends and

inferences that can be drawn from the overall findings. With regard to the participants' abilities in English, their responses to the question "Do you speak English?" and "If so, how proficient are you?" were recoded into a scale of 1-3. The number one was designated for those who wrote that they did not speak any English at all. The number two was reserved for those who qualified their proficiency, either writing that they spoke "*un poco*" (a little), or picking up to two out of the three language skills associated with the question (speaking, writing and reading). The number three was designated for participants who claimed to be fluent in English able to speak, write and read the language.

Findings related to the proficiency scale reveal that those who speak no English do not differ from fluent English speakers, in terms of satisfaction with their healthcare. Although chi-square tests showed the results to not be statistically significant, a pattern consistently emerges in the data between the different groups. Number ones (the non-English speakers) and number threes (the fluent English speakers) ironically have similar responses to questions asked on the survey. Seventy four percent of both groups maintained that there were no language barriers between them and their physicians (Figure 1). When participants were asked if they ever felt unable to communicate their needs due a language barrier, 82% of both groups did not cite it as a problem (Figure 2). Number ones and threes matched up at 82% again when both groups answered "no" to the question asking whether a language barrier has made them feel unsatisfied with their healthcare (Figure 3). Additionally, both groups visit their Doctors with the same frequency (Figure 4).

The pattern evident in the crosstabulations also applies to the number twos, the limited proficiency group, whose answers consistently differed from the number ones and threes. Eighty three percent of these participants who “*se defiende*” (can get by) did not believe there to be a language barrier between them and their physicians, even more so than non-English speakers and fluent English speakers (Figure 1). Only half of the number twos said that they ever had problems communicating with their physicians (Figure 2). This is especially interesting to note, considering that 92% of the group nonetheless claimed to feel satisfied with the healthcare they receive (Figure 3).

Figure 1
English Proficiency*Language Barrier Crosstabulation

$\chi^2(2) = .11$ p=.95		Language Barrier		Total
		A Yes	B No	
English Proficiency	1	4	15	19
	2	2	10	12
	3	4	15	19
Total		10	40	50

Figure 2
English Proficiency*Unable to Communicate Crosstabulation

$\chi^2(2) = 2.35$ p=.31		Unable to Communicate		Total
		A Yes	B No	
English Proficiency	1	5	14	19
	2	6	6	12
	3	5	14	19
Total		16	34	50

Figure 3
English Proficiency* Unsatisfied Crosstabulation

$\chi^2(2) = .42$ p=.81		Unsatisfied		Total
		A Yes	B No	
English Proficiency	1	3	16	19
	2	1	11	12
	3	3	16	19
Total		7	43	50

These results lead to questions as to why limited speakers of English are just as satisfied as fluent English speakers, with regard to communication between themselves and their physicians. Correlating data -- which did prove to be statistically significant -- also shows those who speak little English visit their Doctor more frequently than their counterparts (Figure 5). The group of limited English speakers cited that language barriers exist with their medical provider, as well as experiences of feeling unable to communicate all of their concerns. However, findings show that the patients are satisfied with the current healthcare they receive.

Figure 5
English Proficiency*Frequency of Medical Visits

$X^2 (2) = 6.27 \text{ } p=.04$		Frequency of Medical Visits		Total
		1-2 times/week or 1-2 times/month	1-2 times/6 months or 1-2 times/year	
English Proficiency	1	7	12	19
	2	9	3	12
	3	6	13	19
Total		22	28	50

One may interpret this as a sign that limited English speakers who attempt to communicate on their own are at a disadvantage; they may comprehend more than people who admit to not speaking English at all, but inevitably there are gaps to understanding the situation as a whole. While non-English speakers are forced to utilize interpreters, hotlines and bilingual services, patients with limited proficiency often fend for themselves. Miscommunication and ineffective treatment can be a result of this semi-autonomy, causing patients to make more frequent trips to the Doctor in order to get their problems addressed. This provides a possible explanation for why semi-proficient

English speakers feel less able to express their needs than non-English speakers, and why the former go see their physicians more often than either of the groups analyzed.

Sixty-two percent of non-English speakers and those with limited proficiency did not cite that a language barrier existed between them and their Doctors. However, these groups did not think there was any other factor apart from language that contributed to miscommunication with their provider. As Figure 5 illustrates (with data determined to be statistically marginally significant), mainly fluent English speakers mentioned there to be other communication problems. “*Racismo*” (racism), “*respetar las opiniones del paciente*” (respecting the patient’s opinion) and “*la sensibilidad hacia otras culturas*” (sensitivity about others’ cultures) are examples provided by the patients themselves. It is interesting to note that those who are able to fully partake in the dynamic of the patient-Doctor relationship are the most likely to be able to recognize areas of improvement. While patients who do not speak English fluently get their basic needs taken care of, underlying problems are not addressed with the medical treatment they receive. The presence of a language barrier could either prevent such patients from recognizing other communication issues, or it might be enough of a hurdle to lead patients to ignore them.

Figure 6
English Proficiency*Other Communication Problems Crosstabulation

$\chi^2 (2) = 5.6 \text{ } p=.06$		Other Communication Problems		Total
		A Yes	B No	
English Proficiency	1	1	18	19
	2	3	9	12
	3	7	12	19
Total		11	39	50

Still, it is evident that limited English speakers, along with those who do not speak English and those who speak that language fluently, are satisfied with the healthcare they receive (Figure 3). Such findings reveal that despite problems associated with patients getting their point across, they feel as though their needs are ultimately addressed. One explanation for this is the context in which the participants were getting treated. For one, the patients indicated that the reason they went to their respective medical providers was because of the availability of bilingual personnel. At the time these patients were surveyed, they had already sought out services that would be useful to them. While they might have had issues with communicating their concerns previously, the sites in which the research was conducted were presumably ones that had the best services available to offer for Spanish-speaking patients.

Another rationale behind the satisfaction with healthcare from non-English/limited-English speakers is the personal resources that are used by such patients in times of need. For example, patients were asked how there were never any language barriers between themselves and their Doctors despite the fact that not all of their providers spoke Spanish. The responses all showed that the patients had had to use either relatives or strangers to assist them, and act as their interpreters in health situations ranging from translating in the midst of child birth to expressing a desire to get referred to an ophthalmologist.

One male participant, for example, was unable to get psychological treatment at the Community Health Center prior to their hiring a part-time Spanish-speaking therapist. As a non-English speaker, he was told that there were available psychologists in the area who could be of assistance to him. This search process necessitated him to employ the

skills of his English-speaking daughter, who acted as a translator for him for several months. This participant did check off “Yes” to the question asking whether he has ever felt incapable of communicating his needs because of a language barrier, but said “No” to questions asking if he had ever felt unsatisfied with healthcare because of language barriers. When asked about how this was possible, considering his experiences, his response was “*mi hija me traducía*” (my daughter translated for me).

Daughters, wives, sisters, and female cousins were often mentioned in terms of the assistance they provided their male relatives by acting as translators. In fact, one male participant commented that he relied on his wife to interpret for him ever since their arrival to the United States in 1971. Without her, he joked, he would go back to Colombia. This dependency on women to communicate in a healthcare setting can provide an explanation for the language proficiencies between the genders among the participants. The chi-square test for the relationship between sex and proficiency in English was statistically significant: Women were shown to have substantially more English speaking skills than men, and dominated the fluent English end of the proficiency scale. Furthermore, the males greatly outnumbered females in lowest proficiency end of the scale, two thirds of whom wrote that they spoke English at all (Figure 7).

Figure 7
English Proficiency*Sex Crosstabulation

$\chi^2(2) = 7.48 \text{ } p=.02$	English Proficiency			Total
	1	2	3	
Sex F	9	10	16	35
M	10	2	3	15
Total	19	12	19	50

Such results indicate that women either are inherently more capable of language acquisition than men, or they become subjected to learning the language because of constructed gender roles in relationships. In entering a debate over “What came first, the language skills or the assumption of them?” one can understandably appreciate the position in which bilingual women are placed in their relationships with male non-English speakers. The likelihood of women being more proficient in English is either a consequence or reason to being interpreters for the men in their lives. In any case, they bear the responsibility and burden of communicating for males in a healthcare setting.

For the data analysis, reasons provided by patients as to why they did not learn English were categorized in terms of Personal, Circumstantial and Language reasons. For “Personal” reasons, answers related to one’s perceived capabilities made to learn the language were included, such as “*No tengo el cerebro*” (I do not have the mind for it) and having problems with “*la memoria*” (memory). “Circumstantial Reasons” dealt with issues associated with a lack of education, limited resources, and conditions that led patients to not make English a first priority. Examples of such responses are “*no tiempo por mi trabajo y familia*” (no time because of work and family)” and “*disabilidad*” (being disabled), all of which did not allow for time for the participants to learn the language. Under “Language,” problems related to English itself were factors, mostly “*pronunciación*” (pronunciation) and “*la gramática*” (grammar).

Data from the surveys reveals that the majority of participants, 42%, did not learn English because of circumstantial reasons. “Language” was indicated as the next primary reason by 26% of the participants. Only 4 of the 31 participants who were not fluent in English attributed their lack of proficiency to personal reasons (Figure 8). In conjunction

with the interviews conducted with the participants, the results indicate that the Spanish-speaking patients wanted to learn English. However, time divided between jobs and taking care of families left little opportunity to take language classes and converse with English speakers.

Figure 8
English Proficiency*Reason for Limited Proficiency Crosstabulation

$\chi^2(3) = 1.2 \text{ } p=.75$		English Proficiency		Total
		1	2	
Reason	None	4	3	7
	Circumstantial	10	4	14
	Language	3	3	6
	Personal	2	2	4
Total		19	12	31

Taking into account the reasons why Hispanics immigrate to the United States in the first place, the limited amount of time that Spanish-speakers can dedicate to learning English is logical. Several patients who were interviewed remarked that they did not, in fact, have to learn English because they were always surrounded by people who spoke Spanish. One woman, for example, first moved to Los Angeles from El Salvador and stayed with family before moving to New London. Both regions have Hispanic populations which made her feel comfortable and allowed to her converse freely. However, this did not force her to speak English and as a result, has lived in the United States for 15 years without learning the language. Her comment that, “*en parte me ha ayudado, en parte no*” (in part, it has helped me, and in part it has not) reveals that while she appreciates the ease of communicating between Spanish-speaking people, she feels that living amongst Hispanics made it more difficult to learn English.

This ambivalence can be attributed to one's ability to live in the United States and manage to cope without knowing English. As seen with the patients who were interviewed, finding a medical facility that offers bilingual services is not always a challenge, since previously established networks refer people to providers who can communicate with them. However, various specialties in medicine and health prove to be more of a problem and many are left to either go outside of their local area for help or forego getting a consultation altogether. One female, for instance, mentioned how difficult it was to work with her OBGYN when she was pregnant with her first child. Since she did not understand the word "push" and her Doctor did not speak Spanish, this inevitably caused an added level of stress for her while she was giving labor. Another participant had success in finding Spanish-speaking general practitioners, but her quest to find specialty Doctors with whom she could communicate also proved to be more troublesome. The Community Health Center she frequents was able to find an ophthalmologist who spoke a bit of Spanish, but, after she left the city, the patient was unable to get in contact with someone else who could be of help in the region. Furthermore, she was unable to find a gynecologist or urologist who could speak Spanish, although she was advised to make an appointment with such specialists. Lack of resources for Spanish-speakers in the field of mental health is even more problematic, as psychology and psychiatry are areas that heavily rely on communication and the ability to express one's feelings.

It is often wondered how those who live in the United States for decades never come to learn English, the dominant language. This can be explained by considering the "immersion" process for Hispanic immigrants: Spanish-speakers settle into language

communities with people from similar backgrounds, leading them to not have any real exposure to English. Those who do learn English tend to be first-generation Americans, who are often able to do so at the expense of their parents' struggle. The daughter of the male participant, for instance, attributed her proficiency in English to be a result of having experiences that were not afforded to her father. While he worked to provide for the family, she had the opportunity to converse with English speakers. She claimed that "*la mayoría de los hispanos vienen acá por la misma razón -- solucionar sus problemas y tener más oportunidades*" (the majority of Hispanics come here for the same reason -- to solve their problems and have more opportunities). Because economic hardship and general instability can be driving factors of emigration from Spanish-speaking countries, learning English may not be one's first priority while establishing oneself in the United States. Another participant said, "*La mente de la gente aquí es trabajar para mandar a su gente allá*" (The mindset of the people here is to work in order to send [money] to their people there).

The promise of prosperity in the United States also a topic addressed by Iris Morales, an activist and former member of the Young Lords, an organization that was started in late 1960s. The Young Lords consisted primarily of first-generation American Puerto Ricans, sons and daughters of parents who were a part of great migration of the 1940s. Morales mentioned that their parents "came to New York City because of the economic situation in Puerto Rico after the Mayor had recruited them for labor" (Morales, interview). These immigrants faced struggles in Puerto Rico associated with liberation as well as dealing with struggles within the United States.

Aside from dealing with economic burdens and issues associated with immersion, newly settled Puerto Ricans had “high rates of Tuberculosis, access to healthcare was poor, and there was a lack of access to education” (Morales, interview). Morales and fellow Young Lords took over a hospital in New York as a part of the Health Revolutionary Unity Movement, in response to the unequal access to healthcare in the Puerto Rican community. When asked about whether interpreting between patients and Doctors was a prime concern, Morales said that language barriers were only part of the overall problem: “We didn’t really make those distinctions, but we said there should be translation at all times for those who need it. You had to look for people around the hospital or clinic... to find someone to translate for you” (Morales, interview).

Morales also shared a personal experience she had involving the issue of communication between Spanish-speaking patients and their providers:

My mother was already in her ‘60s and they found that she would have to have a hysterectomy – I was livid because there was no explanation, it was just made out to be routine. I was translating for her and the Doctor said, ‘Tell her it won’t affect her sex life.’ I was mortified...not about to talk to my mother about her sex life. I didn’t translate that for him and I said, ‘I’m requesting a second opinion.’ While I was sitting in the waiting room, the medical director saw me reading a law book and he engaged me in a conversation... so I told him that I was seeking a second opinion. That night I got a call from the head of the department, that there had been a mistake made, and that in fact, it was a misreading of the test. To this day I think they feared that since I had preliminary language of the law that I might bring a lawsuit [to them]. (Morales, interview)

It is evident in this case that language was an indication of social status and power. In Morales’ case, her mother’s inability to speak English led her to be regarded as

disposable as her health was not seriously evaluated. With the knowledge of English, on the other hand, Morales posed as a threat since she was able to express her dissatisfaction and speak out against her frustration. Related to her story, Morales discussed the practice of sterilization of Puerto Rican women (Operación). As a subject that she had confronted and publicly addressed, she was able to bring light and fight an injustice that she braved to face.

Language, in this sense, serves as a means of expression as well as provides its speakers with a degree of influence. As one participant commented, “*Inglés es el idioma número uno, y vine acá de Puerto Rico para que mis hijos lo aprendan*” (English is the number one language and I came here so that my children could learn it). For those Spanish-speaking patients who do not speak English, voicing their concerns is not always feasible and they must make use of their resources in order to meet basic needs.

Even though language barriers are regarded problematic in healthcare, they serve as but one example of the barriers faced by Hispanic immigrants in general. In response to a question about what sorts of cultural factors contribute to disparities in medical care, Morales commented:

I know that translation is a piece of [the problem] but it also ties to the racism that exists in the system... It's about knowing what people eat, what a person's diet might be, what a person's routine might be if they're experience stress, knowing that the woman is taking care of the kids. It's about...acknowledging any racial bias they might have, working in low income communities. (Morales, interview)

Being familiar with a patient's lifestyle and customs are as equally valuable as speaking the same language. It not simply about vocabulary, but about providers being aware of

any preconceived notions they have about their patients. Moreover, quality service entails an understanding as to how medical treatment fits into the context of clients' lives.

Finding a solution to such a problem, however, must be taken in steps and dealing with language barriers is one way to approach the situation. When asked about where the responsibility lies, Morales thought that everyone should take part in ensuring communication in healthcare. By making it an either/or issue, she argued, people lose sight of the overall problem and don't analyze it in order to come to a full understanding of the situation. Still, Morales said, "If you asked me to prioritize, I would say to provide translators because learning a language takes time. What are you going to do, not have access to healthcare?" (Morales, interview)

The survey given to participants addressed this question by asking whether patients should learn English, Doctors should learn Spanish, interpreters should be provided, or a combination of the options. The data obtained using SPSS were revealed to be statistically insignificant results, but also indicated that there was no sense of agreement amongst the participants (Figure 9).

Figure 9
English Proficiency*Solution Crosstabulation

$\chi^2(8) = 3.2 \text{ } p=.92$		English Proficiency			Total
		1	2	3	
Solution	Patient	6	3	3	12
	Doctor	4	2	3	9
	Interpreter	4	4	8	16
	Combination	4	3	4	11
Total		19	12	19	50

There were those who said that patients and should make more of an effort, while others said it would make sense for Doctors to be the ones to learn another language. The latter opinion was often given in the context of patient satisfaction and a resignation of their provider's presumed higher capabilities. Such answers included: "*Me sentiría más cómodo*" (I would feel more comfortable) and "*ellos tienen más capaz*" (they are more capable)." Nevertheless, such a scattered data set shows that there is no consensus about the matter, and that patients themselves struggle with understanding what should be done about the dilemmas they face.

In considering the data analysis and interviews conducted, one can see that bilingualism in healthcare is a controversial issue that bring along many different perspectives. Some argue that language barriers prevent patients from receiving quality medical care, and others simply see it as an inconvenience that goes along with immigrating to the United States. While there are patients who can easily find Spanish-speaking general Doctors to treat them, locating a psychiatrist can prove to be nearly impossible. However, even though federal mandates to provide culturally and linguistically appropriate services are not always successful, it is clear that efforts have been have been made in response to growing Hispanic populations and their needs. As Iris Morales said, "The theme of translation has to be part of a dream, a dream that has to be big. If you have little dreams then nothing will happen and you have to move along a continuum" (Morales, interview). The big dream, in this case, is to ensure equal access to healthcare for Spanish-speakers, a vision that includes communication between patients and their providers.

CHAPTER TWO

~*~

CAPÍTULO DOS

TOGETHER

“Paging Dr. Seoh,” blasts the intercom. “Please report to the front desk.”

I swirl amongst the crowd of people waiting at the check-in area, and enter the main office where I pick up the file for my ten-o-clock appointment. “Mrs. Guerrero is waiting in your office Doctor,” the secretary tells me, rolling the double R’s of the patient’s surname. I open the folder and look at the client’s history with the clinic. *Another I.T.* I sigh and wonder how I will ever make progress with clients if half of my time is spent doing initial evaluations. The name written in elegant cursive on top of the form reads “Maria Luisa Guerrero.” *I hope this patient speaks English,* I say to myself. *I told them to stop sending me people that I have to eventually turn away because we can’t communicate with each other.*

Recognizing my feelings of both resentment and admiration, I question yet again the source of my ambivalence towards Spanish-speaking patients since I started to treat to them. I recognize the hardships that immigrants face, and I understand that one can’t simply learn English in a matter of weeks. Yet I have seen people fail to do so after living in the U.S. for years, raising their children and working in the country. English may only be the nation’s *de facto* language, but it is a universal one that is also spoken by the majority of people in the U.S. I would think that if someone made the effort to move here, it would make sense to try to adapt to our particular culture. I suppose therein lies the confusion -- the country has no defined culture. The slew of races, ethnicities and groups of people has contributed to the nation’s identity, yet the population is left without a clear notion of what being an American really entails.

I look at my watch and quicken my pace. *I don't know how my parents did it, moving here from Europe in their twenties and starting a life here while becoming fluent in English.* I wanted to know more about my Hispanic patients, which my experience has shown that they overcome many adversities and obstacles in the process of integrating into North American society. Inevitably though, I feel powerless to be of assistance, because I am forced to send clients to others who can communicate with them. We have numerous pamphlets, staff and a few medical providers who can be of help when necessary. That, however, still leaves much room for improvement, as the influx of immigrants from the Dominican Republic, Puerto Rico and Peru have placed more of a demand on bilingual health professionals.

Heading towards my office, I navigate through a sea of people and Spanish: “*Es que mi hijo está enfermo*”... “*Si, tengo seguro*”... “*Me gustaría hacer la cita para el jueves que viene.*” If only I could know what they were saying. *Clearly I made the wrong choice by taking French in high school.*

~ * ~

As I walk down the long hallway, I come closer to the door bearing my name plate. After turning the knob and pushing it forward, I meet the eyes of a Hispanic woman sitting in the cushioned chair near my desk, on the opposite side of the room. On the edge of her seat, slightly slumped, with one ankle tucked behind the other, I can sense her discomfort. I have the impression that she was ready to leave at a moment's notice, with a purse placed on her lap, on top of which her hands were firmly clasped. She seems tense, nervous and eager to make progress -- or am I projecting my feelings onto her?

“You must be Mrs. Guerrero,” I say, extending my hand. “I am Dr. Seoh.” After meeting my handshake, Mrs. Guerrero surprises me by bursting out into a series of giggles. She notices my state of perplexion, after which point she immediately stops her behavior and begins to talk. *Inappropriate laughter*, I think to myself, while I become aware of her broken English. *Could just be nervous laughter. Or, it is a possible sign of bi-polar disorder.* Although I know that it is too soon to be making diagnoses, I make a mental note to keep in mind for the rest of the session.

Using my limited Spanish vocabulary and body language, I try to explain to Mrs. Guerrero that we will have to work together in order to come to an understanding about her issues. She indicates that she comprehends and nods her head in agreement. In the very least, I feel as though Mrs. Guerrero is willing to go through the additional burden to ensure that she gets her point across. Looking through her file, I notice that she made the appointment voluntarily, and she was not instructed to do so by any medical Doctor or mental health facility. I start to think about other first-time patients I’ve met who were perfectly able to communicate their ideas, but did not show any sort of internal motivation to do so. *This woman is so determined that she is willing to overcome a language barrier in the process of actualizing her potential.* I shake my head slightly in amazement. *How interesting that such patients who encounter challenges in receiving therapy are the ones who need it the most.*

We manage to get through questions about her medical history, and, in the process, I get to learn more about Mrs. Guerrero and her family life. When she shows me pictures of her children, I see the joy in her face as I get to know their names and ages, one by one. She turns her attention to a framed photo of my own son and daughter, and

expresses interest in them. I start to talk about them, something that I have done many a time with patients and co-workers in the past. While doing so, I become more aware of how much I hold back from telling her, in comparison to what I freely express to people in English. I can only imagine how many stories Mrs. Guerrero has to share about being a mother, about being a wife, about being an immigrant. She and I are both affected by an obstacle that has existed since the precedent set in Babel long ago.

As I move along in the session with Mrs. Guerrero, I come to learn that her main concern is the hallucinations that she has been having; that is to say, we both clarified the problem after several minutes of confusion and gesticulating. I need to know more about these things that she “sees,” to have an idea whether or not she has a disorder induced by these figures, and if she is delusional. After telling me that she sees “*sombras*,” I try to think about what the word could mean.

Sombras, sombras, hmmm.... sounds like somber. Perhaps the people that she imagines are sad. Or, they may actually be making her feel sad. I decide to go forward with my idea and ask how these non-existent figures affect her. Instead of clarifying, though, Mrs. Guerrero responds by introducing another variable in to the equation: she tells me that she hears voices. I want to know more so that I can understand the situation properly, but she can not express what it is that the voices are saying.

At this point, I become more alarmed. When hallucinations reach the point at which they speak to the patient, it is important to know what she or he hears. If Mrs. Guerrero was seeing command hallucinations, for example, she could be compelled to be of harm to herself or others around her. I ask her again to tell me what the illusions are talking about, but Mrs. Guerrero becomes more uncomfortable discussing the issue.

Concluding that there was no other option, I went ahead and told her that we were going to call the language hotline.

Although I think the hotline is a valuable resource for patients and providers who don't speak the same language, I only use it as a last resort. I find that it isn't the most conducive in creating an ideal therapy session. For one, having someone act as an interpreter is problematic. It complicates the dynamic of the relationship that is trying to be built between me and my patient, which is hard enough to do from the start. Also, the patient gets put in even more of an awkward situation by having to go through a longer and more arduous process to express herself. Moreover, using translators leaves room for interpretation of whatever is told to them, which can actually lead to more miscommunication. There's a reason why the game "Telephone" always result in confusion. Nevertheless, the ability to relay valuable information about a patient outweighs the inconveniences of the hotline, so I opt to use it when needed.

"Hello? Hi, I need an interpreter... Yes, for a Spanish-speaking patient... Oh, good afternoon Nancy, I'm in a therapy session right now, and I've just become aware that my client has been having hallucinations that speak to her... Well, I need to know exactly what she sees and what they illusions are actually saying... Ah, her name is Guerrero, Mrs. Guerrero. Hold on, I'll put you on speakerphone."

Nancy begins to speak in Spanish, and I look over to Mrs. Guerrero who leans forward, attempting to catch the somewhat muffled, high-pitched voice of the translator. As I expected, Mrs. Guerrero had difficulty hearing Nancy from where she was sitting. I motion for her to sit next to me, in order for her to better listen and talk in to the phone. This presents another problem with the hotline. Technically, I am supposed to have a

leg's distance from a patient, in the event that I should have to protect myself. Along those lines, I should also be the person closest to the door if I need to run out and confine a particular client having an episode. However, using the hotline forces me to give up those safeguards; I am led to sit side-by-side with the patient who ends up blocking my exit, due to the limitations of my office space. Nancy's explanation of Mrs. Guerrero's harmless hallucinations, though, leaves me feeling less stressed, and we continue with the rest of the evaluation. I conclude that she is not, in fact, bipolar, but suffers from depression with psychotic features. Although I am relieved to have a better idea about her mental health status, I know that she will have to consistently go to therapy to confront her disorder.

By the end of the appointment, I prepare myself for what is to come: deciding how to continue on. Taking into account that I would never be able to fully understand Mrs. Guerrero in an efficient, reasonable way, it seemed unproductive to have me as her psychologist. I would be willing to do it with the help of the hotline or live interpreter, which wasn't a favorable option for either one of us, in my opinion. There was always the Spanish-speaking psychologist in my department, but she worked part-time and was in very high demand. I could always refer to another health facility, but I knew they were also dealing with the same issues and were located far away as well. Ultimately, though, it is the patient's decision. "Nancy," I ask the woman in the phone, "Can you please explain to Mrs. Guerrero our options?"

While Nancy talks in Spanish, I can see the patient's countenance become one of resignation. She asks me my opinion, to which I respond that it is her decision, but to keep in mind that she must feel able to release her thoughts and emotions in order to

really get help. As we three go back and forth in English, English, Spanish, Spanish, English, Spanish, I try to imagine doing this for months at a time.

“Doctor?” Nancy says.

“Yes?”

“The client has decided to be put on the waiting list to see the psychologist who speaks Spanish.”

“Ah, I see. Well, of course. Tell her I that I understand and respect her decision.”
I reply.

I turn to Mrs. Guerrero and wholeheartedly say, “Te entiendo, Maria.” She is not sitting anxiously any longer. Rather, she seems heavily pressed in the chair, her emotions and energy taken from her and released in to the room. We look at one another, and I see her smiling, tired eyes, revealing a sort of depth that I will never get the chance to know. But for a while, we are able to bond without using words. She feels my helplessness, and I know her exasperation. As we sit in silence, our connection remains strong. Fuerte.

JUNTOS

*Esta historia es desde el punto de vista de un angloablante. Sin embargo, por el deseo de comunicar los temas en español, la historia es escrito en este idioma. Se puede leer la historia entendiendo que el Doctor está pensando en inglés, incluyendo cuando se encuentra letras en itálica.

“Paging Dr. Seoh,” oigo por el intercominidor que resuena. “Please report to the front desk.” Ando por un montón de gente que está esperando en el área de la recepción, y entro la oficina central donde recojo la carpeta por mi cita para las diez. “Mrs. Guerrero is waiting in your office Doctor,” me dice la secretaria, pronunciando bien la doble R del apellido de la paciente. Abro la carpeta y miro la historia que la cliente tiene con la clínica. *Otro I.T.* Suspiro y me pregunto cómo progresaré jamás con clientes si la mitad de mi tiempo es gastada haciendo evaluaciones iniciales. El nombre escrito en la letra cursiva elegante encima de la forma lee “Maria Luisa Guerrero.” *Ojalá que esta paciente hable inglés*, me digo a mí mismo. *Les dije ya parar de mandarme más personas que inevitablemente tengo que rechazar porque no podemos comunicarnos.*

Reconociendo ambos de mis sentimientos de resentimiento y admiración, pregunto de nuevo la fuente de mi ambivalencia hacia los pacientes hispanohablantes desde comenzar a tratarlos. Yo reconozco las dificultades que inmigrantes encaran, y entiendo que nadie puede aprender inglés en semanas. Todavía, he visto a personas fallar a hacer así después de vivir en los EE.UU. durante años, bregando a sus hijos a trabajar en el país. Aunque el inglés no es el idioma oficial, su uso es casi universal y también es hablado por la mayoría de la población. Pensaría que si alguien hizo el esfuerzo mudarse aquí, tendría sentido a adaptar a nuestra cultura particular. La mezcla de razas, etnias y

grupos de personas han contribuido a la identidad de la nación, mas la población es dejada sin una noción clara de lo que un americano trae consigo realmente.

Miro mi reloj y apresuro mi ritmo de andar. *Yo no sé cómo mis padres lo hicieron, mudando aquí de Europa en sus años veinte y empezar una vida aquí mientras aprendiendo inglés.* Quiero saber más sobre mis pacientes hispanos, como mi experiencia ha mostrado que ellos vencen muchas adversidades e obstáculos en el proceso de integrar en la sociedad de Norteamérica. Pero inevitablemente, me siento impotente en acudir, porque soy forzado a mandar clientes a otros que pueden comunicar con ellos. Tenemos numerosos folletos, el personal a unos pocos proveedores médicos que pueden ser de ayuda cuando sea necesario. Eso, sin embargo, deja todavía mucho para mejorar, como la entrada de inmigrantes de la República Dominicana, Puerto Rico y Perú han colocado más demanda en profesionales bilingües de salud.

Andando hacia mi oficina, navego por un mar de gente y español: “Es que mi hijo está enfermo”... “Si, tengo seguro”... “Me gustaría hacer la cita para el jueves que viene.” Si solamente podría saber lo que ellos decían. *Claramente me equivoqué, tomando la francés en la prepa.*

~ * ~

Cuando ando abajo por el pasillo, yo vengo más cerca a la puerta que tiene mi plato de nombre. Después de girar la perilla y empujarla adelante, encuentro los ojos de una mujer hispana sentada en la silla almohadillada cerca de mi escritorio, en el lado opuesto del cuarto. Al borde de su asiento, ligeramente desplomado, con un tobillo metido detrás del otro, podría presentir su molestia. Tengo la impresión que ella estaba lista para salir en seguida, con su bolsa colocada en su regazo, encima de que las manos

fueron agarradas firmemente. Ella parece tensa, nerviosa y ansiosa de progresar – ¿o puede ser que estoy proyectando mis pensamientos en ella?

“You must be Mrs. Guerrero,” yo digo, extendiendo la mano. “I am Dr. Seoh.” Después de darme un apretón de mano, la Sra. Guerrero me sorprende y echa a reír. Ella advierte mi estado de perplejidad, después de parar inmediatamente su conducta y empieza a hablar. *Risa inapropiada*, pienso a mí mismo, mientras advierto su inglés roto. *Podría ser apenas la risa nerviosa. O, es un signo posible del desorden bipolar.* Aunque se que es demasiado temprano estar haciendo diagnósticos, hago una nota mental para tener en cuenta para el resto de la sesión.

Utilizando mi vocabulario limitado del español y lenguaje del cuerpo, intento de explicar a la Sra. Guerrero que tendremos que trabajar juntos para venir a una comprensión sobre sus asuntos. Ella indica que ella comprende y asiente con la cabeza. Por lo menos, siento que la Sra. Guerrero está dispuesta a tratar con la carga adicional a asegurar que ella consigo su punto de vista. Examinando su archivo, me doy cuenta que ha hecho la cita voluntariamente, y no fue dicho por ningún médico ni la facilidad mental de salud. Empiezo a pensar acerca de otros pacientes principiantes que he conocido con quién pudieron perfectamente comunicar sus ideas, pero no mostraron ningún motivo para hacer así. *Esta mujer es tan determinada que ella está dispuesta a vencer una barrera del idioma en el proceso de realizar su potencial.* Asiento la cabeza ligeramente en asombro. Que interesante que tales pacientes que encuentran los desafíos en la terapia receptiva son los que rechazan lo más.

Logramos contestar las preguntas sobre su historia clínica, y, en el proceso, tengo la oportunidad aprender más sobre la Sra. Guerrero y la vida doméstica. Cuando ella me

enseña retratos de sus hijos, yo veo la alegría en su cara mientras llego a saber sus nombres y edades, de uno a uno. Ella presta atención a una foto encuadrada de mi propio hijo e hija, y expresa el interés en ellos. Comienzo a hablar sobre ellos, algo que he hecho muchos veces con pacientes y colegas en el pasado. Al hacer así, soy más enterada cuánto tengo que refrenar de decir, con respecto a lo que expreso libremente a personas en inglés. Sólo puedo imaginarme el número de cuentas Sra. Guerrero ofrecería sobre ser madre, marida, inmigrante. Ella y yo ambos estamos afectados por un obstáculo que ha existido desde el precedente hecho en Babel hace mucho tiempo.

Como sigo por la sesión con la Sra. Guerrero, aprendo que su preocupación principal es las alucinaciones que ha estado teniendo; eso es decir, clarificamos dos el problema, después de varios minutos de confusión y gesticulando. Tengo que saber más sobre estas cosas que “ve,” tener una idea si o no ella tiene un desorden inducido por estas figuras, y si ella tiene delirios. Después de decirme que ella ve “sombras,” intento pensar acerca de lo que la palabra podría significar.

Sombra, sombras, hmmm... suena como “somber” en inglés. Quizás las personas que ella se imagina están tristes. O, ellos realmente le hacen sentir triste. Decido avanzar con mi idea y le pregunto cómo estas figuras inexistentes la afectan. En vez de clarificar, sin embargo, la Sra. Guerrero responde presentando otra variable en la ecuación: ella me dice que oye voces. Quiero saber más para poder entender la situación apropiadamente, pero ella no puede expresar que es lo que las voces dicen.

En este momento, soy más alarmado. Cuándo las alucinaciones alcanzan el punto en que ellos hablan con el paciente, es importante saber lo que la persona oye o no oye. Si la Sra. Guerrero estuviera viendo alucinaciones del comando, por ejemplo, podría sentir

obligada a hacerle daño a ella misma o los otros a su alrededor. Yo le pregunto otra vez que para decirme lo que los ilusiones hablan, pero la Sra. Guerrero llega a ser más incómoda hablando del asunto. Concluyendo que me había ninguna otra opción, yo sigo adelante y le digo que vamos a llamar la línea directa del idioma.

Aunque creo que la línea directa es un recurso valioso para pacientes y proveedores que no hablan el mismo idioma, yo sólo la utilizo en último caso. He visto que no es muy eficaz en crear una sesión ideal de terapia. Primero, tener alguien que actúa como un intérprete es algo problemático. Complica la dinámica de la relación que yo y mi paciente estamos desarrollando, que es tan duro hacer del comienzo. También, la paciente es puesta en una situación más difícil por tener que atravesar un proceso más largo y más arduo a expresarse. Además, usando intérpretes permite a ellos a interpretar todo de lo que se lo dicen, que pueden llevar realmente a más mala comunicación. Hay una razón que el juego “Teléfono” siempre resulta en confusión. No obstante, la habilidad de retransmitir información importante acerca de una paciente pesa más que los inconvenientes de la línea directa, de modo que elijo usarla cuando es necesario.

Hello? Hi, I need an interpreter... Yes, for a Spanish-speaking patient... Oh, good afternoon Nancy, I'm in a therapy session right now, and I've just become aware that my client has been having hallucinations that speak to her... Well, I need to know exactly what she sees and what they illusions are actually saying... Ah, her name is Guerrero, Mrs. Guerrero. Hold on, I'll put you on speakerphone.”

Nancy empieza a hablar en español y yo examino a la Sra. Guerrero que se inclina hacia delante, intentando a entender la voz algo amortiguada y aguda de la traductora. Como yo había sospechado, la Sra. Guerrero tenía dificultad escuchando a Nancy de

donde ella se sentada. Le indico que se siente a mi lado, para que escuche mejor y hable en el teléfono. Esta proximidad presenta un problema con el sistema de la línea directa. Según de las reglas, tengo que mantener más de un metro entre la paciente y yo, en caso de que tenga que protegerme. Además, debo ser la persona más cercana a la puerta por si necesito correr afuera y encerrar a un cliente en particular que tenga un episodio. Sin embargo, utilizando la línea directa me obliga a renunciar a esas precauciones y tengo que sentarme al lado de la paciente que está bloqueando mi salida, debido a las limitaciones del espacio de mi oficina. Pero me siento más seguro después de la explicación que me dio Nancy, que las alucinaciones son inocuas. Entonces continuamos con el resto de la evaluación. Descarto la posibilidad que ella sea bipolar y concluyo que ella sufre de la depresión con características psicopáticas. Aunque me siento aliviado por tener una mejor idea acerca del estatus de su condición mental, sé que ella tendría que ir constantemente a la terapia para confrontar de desorden.

Al final de la cita, me preparo para lo que vendrá: decidiéndole como continuar. Tengo en cuenta de que yo nunca sería capaz de entender completamente a la Sra. Guerrero en una manera eficiente y razonable. Parece poco productivo continuar como su psicólogo. Yo estoy dispuesto a atenderla con la ayuda de la línea directa o con un intérprete presente, pero en mi opinión no es una opción favorable para cualquiera de nosotros. Existe la posibilidad de que ella puede ver a la psicóloga hispanohablante en mi departamento, pero ella trabaja a tiempo parcial y tiene muchos pacientes. Yo puedo referirla a otra facilidad de salud, pero sé que también ellos están lidiando con los mismos problemas y están localizados muy lejos. Al fin y al cabo, es la decisión de la paciente.

“Nancy,” pregunto a la mujer en el teléfono, “Can you please explain to Mrs. Guerrero our options?”

Mientras Nancy habla en español, puedo ver que en el semblante de la paciente hay resignación. Ella me pregunta mi opinión, a que respondo que es su decisión, pero que hay que tener en cuenta que debe sentirse capaz de liberar sus pensamientos y las emociones para obtener ayuda verdadera. Cuando nosotros tres seguimos en inglés, inglés, español, español, inglés, español, intento imaginar haciéndolo por meses a la vez.

“Doctor?” dice Nancy.

“Yes?”

“The client has decided to be put on the waiting list to see the psychologist who speaks Spanish.”

“Ah, I see. Well, of course. Tell her I that I understand and respect her decision,” yo contesto.

Giro a la Sra. Guerrero y digo incondicionalmente, “Te entiendo, Maria.” Ella ya se parece ansiosa el asiento. Ella se ve bien atada en la silla, con sus emociones y su energía salidas de ella y liberadas por el cuarto. Miramos el uno al otro y veo sus ojos sonriendo y cansados, revelando un tipo de la profundidad que nunca tendré la ocasión de saber. Pero por un rato, nosotros podemos unir sin usar palabras. Ella siente mi impotencia, y yo sé su exasperación. En silencio, nos quedamos sentado y nuestra conexión se mantiene poderosa. Fuerte.

ANALYSIS

As Dr. Seoh's narrative suggests, serving as a medical provider without being able to communicate with clients can be overwhelming. The inability of patients to express their concerns and symptoms to a healthcare professional often leads to frustration for both parties involved. This certainly affects general practitioners, who must diagnose a variety of illnesses and discuss symptoms in order to effectively devise a treatment plan. The Culturally and Linguistically Appropriate Services implemented by the federal government in 2001 demonstrate that language barriers are, in fact, a problem in healthcare. The mandates, however, are merely a reflection of what organizations were already doing in response to their clients not having access to medical care in their native tongue.

In this Chapter, the relevance of communication in the field of health will be considered from the point of view of the medical provider. Interviews conducted with general practitioners, psychologists, and medical directors have allowed for insight as to how language barriers continue to compromise the quality of healthcare. Hispanics in particular encounter such barriers, considering that they are the largest foreign-language-speaking minority group in the country (García 21). This issue, however, does not only pertain to the United States, as steps have been taken in other countries to confront the matter.

One such example is seen with way in which racial and cultural differences in healthcare are addressed in the School of Medicine at The Universidad Autónoma de Guadalajara. Many internationals attend La Autónoma, located in Jalisco, México, and constitute 20% of the student body ("School of Medicine International Program"). The

Medical School proves to be no exception, with the rising number of aspiring Doctors applying from the United States. As a result, more English-speakers have come to reside and work in clinics in the area (Lozano de la Rosa, Personal Interview). Thus, even in Mexico, language barriers have become more prevalent between patients and those in training to become physicians.

The Medicine in the Community Program, specifically, is further proof of how the University works to achieve a greater understanding between English-speaking providers and Spanish-speaking populations. The program was originally developed in 1935 to provide healthcare to local underserved areas and in 2001 began to offer a Spanish Medical Course during the summertime (“Medical Spanish Course”). Those enrolled in the program work with local physicians, learn medical terminology in Spanish, and become exposed to the dialect and customs of the region. The School’s efforts to train bilingual and bicultural healthcare professionals reveal the importance of communication as seen on both sides of the border.

A site that deals with language barriers in the United States is in Bay Shore, a part of Long Island, NY where Spanish-speakers constitute 19.86% of the population (New York Census 2000). One of the local healthcare facilities is J.R. Medical, a private practice run by Dr. Ignacio Rodriguez. While serving as medical director for over 15 years, Rodriguez witnessed the area’s Hispanic population grow significantly. According to the Doctor, in the late 1980s and early 1990s his practice served about 50% patients who were Spanish-Speaking. Hispanics now constitute around 85% of his clientele. This correlates with the U.S. Census for the 1980s and 1990s, which cite Bay Shore to be made up of 5.8% and 12.4% (New York Census 1980 and 1990, respectively). Even

though there is no definite explanation for this, one possibility is the expansion of factories in the region that provide low-income, labor-intensive jobs. With the availability of such work, many immigrants have moved to the Islip area with the hopes of being employed in an industry that is known to cause accidents and lead to injuries as well as medical conditions. Along with the rise in the number of Latinos, came the need for staff members and medical professionals who could communicate in the patients' preferred language (Rodriguez, interview).

Rodriguez started to offer bilingual services even before there was a federal mandate ordering him to employ qualified staff to translate for patients and/or house materials written in the preferred language of his patients. He had every intention of providing services for Spanish-speaking populations, understanding their needs and concerns as a Colombian immigrant himself. Rodriguez moved to the States when he was fourteen years old, at which time he learned English within six months, "very painfully." Prior to learning English, he and his family who only spoke Spanish were fortunate to not have medical problems. However, he was unable to completely escape healthcare problems associated with language barriers:

[The Doctors] did a PPD on me, a... test for exposure to tuberculosis. I came back positive according to them, and at the time I didn't understand what was going on. It was a big problem because, since I tested positive, they wanted to put me on INH, isonyocide and B6, which we all know is a very toxic drug to the liver... The problem with that was that I was born in Colombia, and everyone that is born in South America, Europe and any other continent except the United States gets vaccinated with the TB vacillus. So your test will be positive. Therefore, because I didn't speak the language I couldn't tell them this, and because I couldn't tell them this, I was put on medication that was potentially dangerous to my liver -- which I took, by the way -- I had

pain for months, but nothing came of it. Later on when I went to [medical school], I figured out what happened, after the fact. (Rodriguez, interview)

When asked about whether or not he thinks medical professional should cater to the language needs of their patients or vice versa, Rodriguez expressed the opinion that immigrants need to consider why and to where they are moving. Ultimately, he believes, responsibility lies on immigrants to adapt to wherever they decide to move. The most tangible and obvious way to do this is to learn the accepted language of the country in question.

By no means, though, should a physician take that as an excuse to avoid learning the patient's language as well. Aside from helping to cross language barriers, Rodriguez argues, being able to communicate with clients will be financially rewarding: Along with other physicians, he does not think that proficiency in more than one language should be made a requirement for Doctors, but that offering resources to patients are a good idea:

It would be silly for anyone who is serving this community, for example, not to have Spanish speaking staff because you're going to lose...customers. Just from an economic point of view, it makes sense that I would hire Spanish-speaking staff because otherwise I'm going to lose my clientele... (Rodriguez, interview)

One way, suggests Rodriguez, that linguistically and culturally appropriate services are valued by physicians would be to consider adding the curriculum of the Medical Schools that train them. Even though the Diagnostic and Statistical Manual of Mental Disorders, for instance, provides examples of "Culture-Bound Syndromes" for mental health professionals, there is no such reference for general practitioners-in-training, in the event

that they would encounter ethnic or race-related medical issues (DSM-IV-TR 897). Business seminars, for example, could point out the monetary and moral value of learning the language of a specific population. This would promote the enabling a patients to communicate health needs, as well as give Doctors-in-training more of an incentive to make such an effort.

With the limited number of medical professionals able to speak a language other than English, a major problem also arises when the issue of specialty Doctors comes into play. Endocrinology, rheumatology, cardiology and psychiatry some of the fields that have very few bilingual physicians (Rodriguez, interview). Generally, the more sophisticated the specialty, the more likely its Doctors will only speak English. This leads to a high demand for different types of physicians unable to communicate with populations in need of their services. For example, even though there are psychiatrists who speak Spanish, by no means are they available in a proportionate number to Hispanics that seek out bilingual therapists. With mental health in particular, which relies on communication for a patients' progress, the problem has also become of concern with psychologists and social workers. So few Spanish-speaking psychologists are available in Bay Shore that patients are referred to people outside of the area, in New York City (Rodriguez, interview).

The need for medical providers who are able to communicate in different languages gives rise to the possibility of recruiting more specialty Doctors that speak Spanish. One way to go about this would be to utilize the H-2/H-2A visa to bring in physicians from Latin America to the United States. However, guest-worker programs have proved to not always be successful and at times have led to internal conflict for all

parties involved (Rothenberg 232). Resentment might ensue from Latin Americans that the Doctors would leave behind, with educated professionals moving outside of their countries to provide services in North America. In addition to this, interpreters and domestic language service employees could feel threatened with the arrival of temporary Spanish-speaking Doctors. Wendy Hess, an immigrant lawyer who largely deals with Hispanic populations, also points out that the H-2A visa is very limiting with its unpredictable quotas and standards as to who is desirable for entry from one year to the next. As is, the program is not a reliable way to respond to the needs of immigrant populations (Hess, interview). The notion of establishing a short-term solution to an overarching problem also lends itself to criticism. A more direct approach to handling language barriers faced by Hispanics in healthcare would be a better way to ensure that they receive linguistically and culturally appropriate treatment.

The implementation of specific services for communities with a large Spanish-speaking population have been evident outside of New York, as seen with The Community Health Center in New London, CT. According to the 2000 U.S. Census Bureau, Hispanics make up 19.7% of city of New London (U.S. Census 2000). Many of these residents are native Spanish speakers, who either have limited proficiency in English or do not speak the language at all. Consequently, various programs in New London have been developed in response to the community's needs. Organizations have worked to help its locals, from hiring more bilingual staff members to creating language courses. Such efforts have been made as a way to assist native Spanish-speakers adapt to their surrounding environment. Centro de la Comunidad, Hispanic Alliance, community-based ESL classes, as well as partnerships with the Office for Volunteers for Community

Service at Connecticut College provide such examples (Melendez-Cooper, interview). With a Hispanic population that accounts for a large part of the city's make-up, such programs are useful in creating more of an integrated neighborhood.

The Community Health Center, or CHC, is a product of the determination to give minorities and underserved populations access to healthcare. Most of the employees are bilingual, and two Spanish-speaking psychologists currently work on part-time bases. The non-profit, federally qualified center has branches throughout Connecticut, including Middleton, Groton and Norwalk. The New London site focuses on medical care, mental health and dentistry, aiming to serve the New London community at large (CHC Inc. pamphlet). In fact, Alejandro Melendez-Cooper who was previously in charge of Centro de la Comunidad -- a local organization devoted to special needs and job readiness programs -- is the current Director of the Community Health Center. The agency has evolved to cater to the needs of locals, namely Hispanics, and have succeeded in creating a valuable network for the residents in New London.

An immigrant from Peru who came to the United States as a proficient English speaker, Mr. Melendez-Cooper did not have to deal with the same complications as the patients who are treated at the Center. However, when asked about the matters that he finds most pressing in healthcare today, he cited language barriers as one of the foremost problems faced by clientele. He also mentions insurance, a dependable support system for people, and status in the country as other prevalent concerns. In response to a question about who need to be confronting this issue, he said: "The patients really need to learn the language -- but providers could learn too. It would really enhance communication... it's not just a one-sided thing, it's a two-way street" (Melendez-Cooper, interview).

Although opposition to linguistically appropriate services is often discussed in terms of the language debate, the programs that have been developed are also a response to the culture gap that exists between Hispanics and Anglos (non-Hispanic white Americans). There are also aspects of medical treatments aside from symptoms that are unable to be communicated. Even among those who can articulate their feelings, there is a sentiment among Latinos that their perspectives on health differ from providers who have been trained in Western medicine (Sherril et. al., 2005).

It is understood that language barriers between patients and medical providers prevent people from communicating their immediate needs. However, they also make it more difficult to relay cultural factors that affect one's health. Being aware of general customs, traditions, and attitudes concerning medicine that are often held by Hispanics can lead to more qualitative treatment and an enriched patient/provider relationship.

Multiculturalism is regarded as an ethical issue in mental health. For example, The Multicultural Guidelines published by the American Psychological Association in 2003 supported the "respect and inclusiveness for the national heritage of all cultural groups" (as qtd. in Fowers and Davidov 584). Along with providing therapy, psychologists thus have a civic responsibility to promote social justice and combat forms of oppression. As Fowers and Davidov argue, openness to the other is an essential part of offering unbiased and quality care (591). This notion of virtue ethics is crucial in offering substantial treatment that corresponds to the needs of patients, and not potential biases of the providers. The issue of providing equal access to limited speakers then not only becomes one about language, but one concerning morals as well.

Considering that providing culturally appropriate services in the preferred language of a patient has been deemed essential, it is interesting to note the different views held by mental health professionals. This is evidenced by the varying opinions found by the employees at the Mental Health Clinic at New London's Community Health Center. Take the stance held by Maritza Bourassa, LCSW, one of the two Spanish-speaking mental health professionals at CHC. Bourassa primarily treats Hispanic patients who are unable to communicate with the other psychologists at the CHC, those who work full-time and are not bilingual. In fact, there is such a large need for her services that Bourassa typically has a month-long waiting list of referrals. Says Bourassa: "I believe that as medical providers we are also responsible. [Patients] can learn English, sure... but if we are truly want to work with our community, knowing how to speak to them in their language will be beneficial for everyone involved" (Bourassa, interview). Those who are of the same mind as Bourassa think that Doctors, nurses, therapists, etc. should make an effort to learn the language and customs of the population being served.

Supervisor Dr. Gary Freudenthal, PsyD, somewhat disagrees. Freudenthal understands the difficulty that many of his Hispanic patients face while they acclimate to a new environment, including learning a new language. However, he also acknowledges that regardless of how many interpreters or translated materials are provided, there is no substitute for being proficient in English:

I'm not going to lie, knowing English will help them in the long run. If we're working to improve their lives in general, I think it's important to recognize how they might be limiting themselves by not speaking the language predominantly used in this country....

(Freudenthal, interview)

Consequently, speaking English in the United States is considered a means to improve one's life and have access to greater opportunities. Perhaps then, more emphasis should be placed on providing tools to help non-English speakers learn the language, instead of relying on assistance from bilingual workers.

Dr. Rachel Duzant, Psy D, a full-time psychologist at the Community Health Center further notes that interpreters are not always the most desirable option. She recalls one instance in which she had to deal with an admitted Spanish-speaking patient who was having a psychotic episode. Although Duzant was able to make out that the patient was seeing hallucinations, she needed to understand if they were saying anything to him in order to evaluate whether he was a threat to himself or others. She called in an interpreter who became anxious and did not do the task given to her. Instead of finding out what Duzant wanted to know from the patient, the interpreter kept trying to calm him down (Duzant, interview). This fortunately did not become a dangerous situation, but in another case such lack of adherence to instructions could have resulted in the patient harming others unexpectedly.

The next issue that arises is the effectiveness of language services and hotlines. Even though interpreters are bilingual, they do not always know how to properly communicate with patients in any given situation. An example of this is seen with the hotline used by the Community Health Center, whose customer requests represent over 170 languages (Language Line Services 2006). Peggie Burnside, an interpreter operation manager explains the standards by which her contract interpreters are hired:

Some have been nationally certified, those who have worked for the federal court... other interpreters are trained

in their state.... it also depends on what the language is. When there is medical training in interpreting organizations, typically those medical interpreters will be able to work in every department. They have it so that it is possible to interpret across general areas in the field of health. (Burnside, interview)

Interpreters are thus hired under the basis of their language skills, and trained to deal with a general range of circumstances. This does not necessarily make them qualified or equipped to deal with specific medical matters, nonetheless psychological cases that require composure and insight as to how to treat a difficult patient (Duzant, interview). The question then arises about the extent that even interpreters should be informed about the field in which they utilized. This brings light to fact the implementation of culturally and linguistically appropriate services apply to all members involved in the treatment of a patient, not just medical providers.

With particular respect to mental health, it is understood that Hispanics who migrate to the United States develop an increase risk of psychological problems, a possible result of the hardship that goes along with acculturating (Bourassa, Interview). Taking into account that Hispanics face such difficulties in American society as discrimination and socioeconomic status, it seems paradoxical that there is a disproportionately low population that seeks the aid of a mental health professional. (Gonzalez 11). Other than the cost of treatment, and quality of available resources, one explanation for such a phenomenon is success of family support systems amongst Latin Americans. This concept of familism contributes a great deal to the way in which a Hispanic patient chooses to identify or handle a medical concern. According to Trandis, Marin, Netancourt, Lisandski and Chang:

Familism refers to the strong identification with and attachment of individuals to their nuclear and extended families; it involves strong feelings of loyalty, reciprocity, and solidarity amongst family members.

(as qtd. in Soriano 71)

Such a connection to the mothers, fathers, siblings, grandparents, etc., within the network leads its members to simply rely on one another for advice and support, in lieu of aid offered by a medical provider. However, for those who do choose to enlist the help of a therapist, familism can be considered beneficial for the client, and problematic as well. The support and close-knit community that a family provides for a patient is extremely valuable. Still, one can see this as a setback, since personal issues are often viewed as private, only meant to be discussed amongst family.

Furthermore, there is often a stigma associated with seeking professional help. This lack of comfort surely contributes to low Hispanic patient populations, but one must also take into consideration the other resources that are used by Hispanics for medical aid. *Curanderos*, or folk healers, are sometimes used as indigenous therapists instead of licensed psychologists or psychiatrists (Gonzalez 12). The use of *curanderos* is more prevalent in Latin America, while healers are used as less of a resource in the United States for those who can afford to see a healthcare professional. In fact, practically none of the patients surveyed in Bay Shore, Long Island or New London, CT admitted to ever having gone to a *curandero*. The few experiences mentioned had either been one of a family member who had sought help and/or an instance that occurred in the person's country of origin. Everyone maintained that living in North America, they would not consider going to a *curandero*, especially if they could pay to see a medical Doctor.

Still, the potential anticipation that a licensed provider would be unfamiliar with Hispanic culture is a reason why a Latin American would opt to go to a *curandero*. Furthermore, such assumptions about racial and ethnic biases would prevent Hispanic patients from revealing that they see a folk healer. Psychologists have even acknowledged the danger of counseling patients who are within an ethnic group with which they are not familiar:

... Psychotherapy [has] done great harm to culturally diverse groups by invalidating their life experiences, by defining their cultural values as different or pathological, by denying them culturally appropriate services, and by imposing the values of the dominant culture on them.

(as qtd. in Fowers and Davidov 581)

Treating Spanish-speaking patients then, is a matter that deals with cultural awareness as well as linguistically appropriate services. For instance, psychiatrists in North America that are unfamiliar with certain values and customs held by Hispanics have been unable to accurately diagnose their patients. Examples of concepts that are liable to be misinterpreted are: “‘spiritualism,’ ‘santeria,’ ‘machismo,’ ‘respeto,’ ‘dignidad,’ ‘ataque,’ ‘black magic,’ ‘visiones,’ and other culturally bound attitudes such as....time notion, male dominance, the idealized female role, and the mother-son relationship” (Marcos and Trujillo 191). Unawareness of such beliefs potentially leads to misunderstandings between providers and their patients. Consequently, the therapist-client relationship is compromised as people reject health professionals who they feel cannot relate to their concerns (Marcos and Trujillo 193). Hence, not being culturally knowledgeable about a local population can cause medical providers to have a predisposed notion of potential

patients. This may result in a learned tendency of such patients to only disclose personal thoughts with those of a similar background.

Although Latin Americans and white non-Hispanics generally agree on what constitutes mental illness, this has only been shown using extreme examples like hallucinations and excessive antisocial behavior (Gonzalez 13). Differences in identifying a mental problem can attribute to a Latin American's lack of an incentive to see a therapist, while another might seek help much sooner. Moreover, studies done by Karno, Ross and Caper in 1969 show that Hispanics are likely to associate a psychological problem with a physiological explanation (Gonzalez 14)). This can cause one to not come to terms with an emotional or mental issue that needs to be addressed, but is instead referred to as a physical complaint. In addition to this, such misconceptions lead patients to choose inaccurate avenues of treatment such as choosing to go to a general Doctor instead of a mental health professional.

It is not difficult for one to consider the strife associated with integrating in to a new culture. The many Latin Americans who travel to the United States do so in order to secure better futures for themselves or their families. Even some has been previously educated or come to eventually speak English, there are populations that maintain their identity and establish networks in communities that only speak Spanish. Inevitably, health issues will arise, and their inability to express what is wrong creates complications. In such circumstances, the debate about whether or not such groups of people should be served in their native language is essentially irrelevant. The need for people to convey their health needs is of the utmost concern, which has been seen to cause more of a dilemma in specialty fields than in general medicine -- in particular, that of mental health.

CHAPTER THREE



CAPÍTULO TRES

WE CARRY ON

Ring, ring.

I fold the last of the laundry and place it on top of the clean pile of clothes.

Ring, ring.

Quickly, I put on my headset and take a moment to adjust it.

Ring, ring.

Before I connect to the language line, I wonder what I will be asked to speak this time. As a trilingual interpreter, each phone call I receive brings about a bit of suspense while I guess which combination of English, French and Spanish will be put to use. I wonder whether my enthusiasm has not waned because of the environment in which I work. Since I am a part of an interpreter operation contract company, I have the luxury of using my language skills from the convenience of my own home.

By no means, though, does that imply that my job is easygoing. While I am able to enjoy the comforts of my living room and kitchen during lulls, I am mostly inundated with calls from organizations that have an account with my company. My training in medical interpretation has also led me to interact more with patients and healthcare professionals who cannot communicate with one another. I look forward to being of assistance in these situations, but to be honest, I sometimes become anxious when the occasion arises. It makes me feel more pressure representing these clients' thoughts and feelings. I feel as though their health is on the line.

The hardest part for me is making sure I do justice to my clients. It's practically impossible to interpret something word for word, so I have to make sure that I get across main ideas of whatever I am told. This becomes problematic when slang is used,

especially within certain dialects that are sometimes challenging for me to understand. Interpreting also involves a certain degree of cultural awareness since miscommunication is often a result of people being unable to relate to one another. For example, at times I have had to explain the concept of *espiritismo* to psychologists. The strong connection felt by people who have lost a loved one is common among Hispanics, although an uninformed therapist might consider a patient in this case to be delusional.

Although these complications can be difficult to deal with, I enjoy conversing with diverse people. I also take pride working to enhance communication between my callers. Ultimately I receive satisfaction knowing that I can help those who struggle to express themselves in a different language. With this reminder, I bring the microphone closer to my mouth and prepare to begin the call.

“This is Nancy, interpreter #270. How may I help you?”

SEGUIMOS ADELANTE

Ring, ring.

Doblo la última tela del lavadero y la pongo encima del montón de la ropa limpia.

Ring, ring.

Con prisa, pongo mis auriculares sobre la cabeza, para después inmediatamente ajustarlos.

Ring, ring.

Antes de que conecte a la línea directa, me pregunto lo que me pedirán hablar esta vez. Como intérprete políglota, cada llamada que recibo me trae un poco de suspenso mientras que conjeturo qué combinación de inglés, francés y español usaré. Me pregunto si mi entusiasmo no ha disminuido debido al ambiente en el cual trabajo. Como soy parte de una compañía de la operación del intérprete, tengo el lujo de usar mis habilidades lingüísticas desde la comodidad de mi propio hogar.

Pero esto no significa que mi trabajo sea fácil. Aunque puedo disfrutar de las comodidades mi sala de estar y mi cocina durante periodos calmos, la mayoría del tiempo recibo llamadas de las organizaciones que tienen una cuenta con mi compañía. Mi entrenamiento en la interpretación médica también ha resultado en más interacciones con pacientes y profesionales de la salud médica que no pueden comunicarse el uno con el otro. Estoy emocionada de ser útil en estas situaciones, pero siendo honesta, algunas veces siento que éstas conllevan un alto nivel de ansiedad. Me siento más agitada cuando tengo que interpretar los pensamientos y sentimientos de estos clientes. De alguna manera, siento que su salud depende de mí.

Lo más difícil para mí es expresar todo lo que mi cliente quiere decir. Prácticamente es imposible interpretar el mensaje palabra a palabra, así que tengo que explicar las ideas principales de lo que me dicen. Esto llega a ser problemático cuando se usan coloquialismos, o cuando se habla en ciertos dialectos diferentes al que yo conozco, lo cual dificulta su comprensión. Interpretar también implica cierto grado de conocimiento cultural, debido a que problemas de comunicación suelen ocurrir entre personas que no pueden relacionarse unas con las otras. Por ejemplo, de vez en cuando he tenido que explicar el concepto de espiritismo a los psicólogos. La fuerte conexión sentida por personas cuando han perdido a un ser querido es muy común entre hispanos. Sin embargo, un terapeuta mal informado puede pensar que su paciente padece problemas psicológicos relacionados con la percepción de la realidad.

Aunque estas circunstancias puedan complicar algunas situaciones, me gusta hablar con grupos de gente diversos. También me siento orgullosa mientras trabajo y entablo más comunicación entre mis clientes. Recibo más satisfacción sabiendo que puedo ayudar a aquellos que luchan para explicarse en otro idioma. Con este pensamiento, acerco el micrófono a mi boca y me preparo para comenzar la llamada.

“This is Nancy, interpreter#270. How may I help you?”

COMUNICACIÓN EN SALUD MÉDICA

In English and Spanish ~*~ *En inglés e español*

COMMUNICATION IN HEALTH

DVD SCRIPT

EL GUILLÓN DEL DVD

*This is a script for the DVD enclosed with Chapter 3. Scenes that introduce each section are done in Spanish with subtitles that correspond to the translation provided in the script. An animated PowerPoint presentation is used as a part of the DVD, with the narrator's voice dubbed as each word is pronounced in English and Spanish. A simplified version of the slides is shown in the script while a printed version is available in Appendix E.

[Shot of me talking in front of the camera]

¡Buenas! Me llamo es Jessica y voy a hablar sobre terminología de salud médica en español e inglés. Específicamente, esta presentación discutirá palabras y frases diferentes que se encuentran en una clínica.

Hello! My name is Jessica and I will be talking about medically related terminology in English and Spanish. Specifically, this presentation will address different words and phrases typically found in a clinical setting.

1. FRONT DESK

[Point to easel with “Front Desk” written below “La Recepción”]

Primero, vamos a repasar términos apropiados que se encuentran en la recepción, o “the front desk.”

To start, let us review appropriate terms that come into play at the front desk.

[Slide appears with the vocabulary below, with voice dubbing in the background]

Para tener una mejor idea sobre su historia, el personal le va a preguntar sobre su información personal, o “personal information”:

<u>Información Personal</u> <u>Personal Information</u>	
<i>Nombre</i>	Name
<i>Dirección</i>	Address
<i>Apellido</i>	Last Name
<i>Casado(a)/soltero(a)</i>	Married/Single
<i>Número de telefono</i>	Telephone number
<i>¿Cuál es su idioma preferido?</i>	What is your preferred language?
<i>¿Tiene seguro?</i>	Do you have insurance?
<i>¿Ha sido vacunado/a para ___?</i>	Have you been vaccinated for ___?

2. GENERAL DOCTOR

[Point to easel with “waiting room” written below “sala de espera,” as well as “General Doctor” below “Médico General”]

Después de la sala de espera, o “waiting room,” conversaciones con su médico general (su “general Doctor”) puedan implicar palabras y frases nuevas:

After the waiting room, conversations with your general Doctors might involve new words and sentences:

[slide appears with the following vocabulary, with voice dubbing in the background]

Preguntas (“questions”) que se pueden encontrar son:

<u>Preguntas</u> <u>Questions</u>	
<i>¿Por qué viene a consulta?</i>	Why did you come for a consultation?
<i>¿Cómo se siente?</i>	How do you do feel?
<i>¿Tiene fiebre?</i>	Do you have a fever?
<i>¿Dónde le duele?</i>	Where does it hurt?
<i>¿Orina Usted con frecuencia?</i>	Do you urinate frequently?
<i>¿Tiene Usted los tobillos hinchados?</i>	Do you have swollen ankles?

[Slide appears with the following vocabulary, with voice dubbing in the background]

Ejemplos de expresiones (“expressions”) incluyen:

<u>Expresiones</u> <u>Expressions</u>	
<i>Estoy enfermo/a - I am sick</i>	
<i>Estoy resfriado/a - I have a cold</i>	
<i>Necesito una radiografía de:</i>	I need an X-ray of:
- la cabeza	- my head
- la rodilla	- my knee
- el pecho	- my chest
- mi mano	- my hand
<i>Me duele_____:</i>	My _____ hurts:
- el estómago	- stomach
- el cuello	- neck
- la garganta	- throat

3. DENTIST

[Point to easel with “The Dentist” written below “El/La Dentista”]

También hay vocabulario específico que se usa con el/la Dentista (“the Dentist”).

There is also specific vocabulary that is used with the Dentist.

[Slide appears with the vocabulary below, with voice dubbing in the background]

Algunas preguntas “questions” que el/la Dentista quizá tendrá incluyen:

Preguntas

Questions

¿Cuántas veces al día cepilla Usted los dientes?

How many times a day do you brush your teeth?

¿Que pasta dentífrica usa Usted?

What type of toothpaste do you use?

¿Le duele cuando toma algo muy frío?

Are you in pain when you drink something very cold?

¿Ha tenido una limpieza?

Have you had a cleaning?

¿Usted usa seda dental?

Do you use dental floss?

[Slide appears with the vocabulary below, with voice dubbing in the background]

Algunas expresiones (“expressions”) que el/ la Dentista le puede usar son:

Expresiones

Expressions

Enjuégese con agua y sal

Rinse with saltwater

Abra la boca

Open your mouth

Cepílese los dientes

Brush your teeth

Necesita empastar su diente

You need to get your tooth filled

[Slide appears with the vocabulary below, with voice dubbing in the background]
Las clases de dientes (“Types of teeth”) son:

<u>Clases de dientes</u> <u>Types of teeth</u>	
<i>el incisivo</i>	incisor
<i>la muela</i>	molar
<i>la muela de juicio</i>	wisdom tooth
<i>el canino</i>	canine

[slide appears with the vocabulary below, with voice dubbing in the background]
Además, es bueno saber vocabulario general (“general vocabulary”) para una cita con el/la Dentista:

<u>Vocabulario General:</u> <u>General Vocabulary:</u>	
<i>aliento</i>	breath
<i>la boca</i>	mouth
<i>la carie</i>	cavity
<i>la corona</i>	crown
<i>el canal en la raíz</i>	root canal
<i>la placa</i>	plaque
<i>la encía</i>	gums
<i>dormido</i>	numb
<i>novocaina</i>	novacaine

4. MENTAL HEALTH

[Point to easel with “Mental Health” written below “Salud Mental”]

Palabras asociadas con salud mental, o “mental health,” puede ser útiles, en el caso de que consulte a un/a Psiquiatra o un/a Psicólogo/a.

Words related to mental health might also be useful, in the event that you see a Psychiatrist or Psychologist.

[Slide appears with the vocabulary below, with voice dubbing in the background]
Preguntas (“Questions”) que su terapeuta pueden hacer son:

Preguntas
Questions

¿Algo traumático le ha ocurrido recientemente?
Did something traumatic happen to you recently?

¿Hay algo específico que le causa sus síntomas?
Does something specific trigger your symptoms?

¿Alguna vez se ha hecho daño?
Have you ever caused harm to yourself?

¿Ha tenido pensamientos sobre suicidio?
Have you had thought about suicide?

¿Ve o escuche a alguien que nadie de su alrededor puede ver ni escuchar?
Do you see or hear anyone that no one around you can see or hear?

[slide appears with the vocabulary below, with voice dubbing in the background]
Algunas expresiones (“expressions”) que quizá usará son:

Expresiones
Expressions

No he dormido desde_____ I have not slept since_____

No me siento como mi mismo/a I am not feeling like myself

Me siento fuera de onda I feel out of it

Muchas ideas se agolpaban en mi cabeza Many ideas race through my head

Me pierdo en mis propios pensamientos I get lost in my own thoughts

Nada me satisface ni me da placer Nothing satisfies me or gives me pleasure

[Shoot to me talking into the camera]

Es importante reconocer síntomas que tienen que ver con la depresión, en vez de atribuirlos a algo somático, o problemas del cuerpo.

It is important to recognize symptoms that have to do with depression, instead of attributing them to something somatic, or problems with the body.

[Slide appears with the vocabulary below, with voice dubbing in the background]

Vocabulario que tiene que ver con síntomas de Depresión (“symptoms of Depression”) es:

<u>Síntomas de Depresión</u> <u>Symptoms of Depression</u>	
<i>Me siento:</i>	I feel:
- Culpable	- Guilty
- Irritable	- Irritable
- Agotado/a	- Exhausted
- Decaído/a	- Down
- Cansado/a	- Tired
- Desesperado/a	- Hopeless
- Ansioso/a	- Anxious
- Tenso/a	- Tense
- Acabado/a	- Drained

[Slide appears with the vocabulary below, with voice dubbing in the background]

Más vocabulario para otras emociones (“emociones”) es:

<u>Emociones</u> <u>Emotions</u>	
<i>Sentimientos de:</i>	Feelings of:
<i>Intranquilidad</i>	Restlessness
<i>Esperanza</i>	Hope
<i>Lástima</i>	Sympathy
<i>Emoción</i>	Excitement
<i>Felicidad</i>	Happiness

5. MEDICATION

[Point to easel with “Medication” written below “Medicamento”]

El uso de los medicamentos, o “medication,” es muy importante y entender las instrucciones como tomarlos es necesario.

The use of medications is extremely important and to understand instructions about taking them is necessary.

[Slide appears with the vocabulary below, with voice dubbing in the background]

Otras expresiones (“expressions”) relacionadas con la medicina que se puede usar son:

<u>Expresiones</u>	<u>Expressions</u>
<i>A mí no me cae bien</i>	It doesn't sit well with me
<i>Me siento un dolor agudo/sordo</i>	I feel sharp/dull pain
<i>Soy alérgico/a a los antibióticos</i>	I am allergic to antibiotics
<i>Necesito algo para mi hipertensión</i>	I need something for my hypertension
<i>No puedo mezclar esos medicamentos</i>	I cannot mix those medications

[Slide appears with the vocabulary below, with voice dubbing in the background]

Ejemplos de instrucciones (“instructions”) para los medicamentos son:

<u>Instrucciones</u>	<u>Instructions</u>
<i>Tome la medicina:</i>	Take the medicine:
<i>- antes de cada comida</i>	- before each meal
<i>- cada seis/ocho horas</i>	- every six/eight hours
<i>- entre comidas</i>	- between meals
<i>- en ayunas</i>	- before eating
<i>- al acostarse</i>	- before bedtime

CLOSING

[Cut back to me in front of the easel, with the word “appointment” written below “cita”]

Ojala que haya disfrutado esta presentación y que haya aprendido algo que será útil para su cita, o “appointment.” ¡Tenga un buen día!

I hope that you have enjoyed this presentation and that you have learned something that will be useful for your appointment. Have a good day!

CONCLUSION

When evaluating the role that language plays in the world, one is led to question its significance. How can language be expected to truly convey one's thoughts, ideas and feelings when it is only comprised of constructed and arbitrary symbols? If language is merely an attempt to articulate what can never be expressed, then what is the point of trying to do so? Moreover, if expressing oneself using language is ultimately meaningless, what is the motivation to become multilingual? Regardless of whether these questions can be answered, language is used as a means to communicate in society. This poses a unique problem for those living within the United States, a country comprised of many different people who speak many different languages. Communicating between these various groups can pose as a problem for those who are unable to speak English, the *de facto* language of the nation.

Communication is particularly significant in healthcare, considering that medical treatment is conducted according to what a patient expresses to be problematic. There is also the issue of the quality of the service provided when there is the presence of a language barrier. One might presume that a physician's inability to thoroughly converse with his/her patient would compromise the perceived level of satisfaction from either party. However, surveys and interviews conducted with Spanish-speaking patients at J.R Medical in Bay Shore, NY and The Community Health Center in New London, CT reveal that this is not true for all cases.

Many of the Spanish-speaking patients acknowledged that they had been treated by healthcare professionals who only spoke English. In particular, patients found it difficult to find physicians trained in specialty medicine (such as mental health,

cardiology and gynecology) who spoke Spanish. Yet eighty percent of the participants did not perceive there to be a language barrier with their providers. An even greater percentage claimed that this did affect their satisfaction with the treatment they received. Despite these results, nearly all of the participants denied there to be any other communication problems in healthcare aside from language barriers. When asked about a possible solution for this issue, there was no statistically significant data as to whether Doctors, patients, interpreters are responsible for ensuring better communication in medicine. This reveals that while there is an understanding that limited English speakers are at a disadvantage while getting medical treatment, there is no consensus among such patients as to what do to about the situation.

A data set that did prove to be statistically significant examined the correlation between gender and proficiency in English. Results showed that Spanish-speaking male patients' language skills drastically differed from that of Spanish-speaking female patients. For example, over half of the females surveyed indicated that they were fluent in English and could read, speak and write the language. In comparison, only twenty percent of the male participants identified themselves as fluent while two thirds of them said that they did not speak English at all. Discussions with the patients revealed that in fact, many women were used to interpret for their husbands or male relatives. Although some had learned English prior to coming to the United States, most had come with as much of an educational background as their male counterparts. Inferences these results include that in a traditional relationship between Hispanic women and men, the former are deferred to as the communicators by their male companions. Questions arise as to whether this implies that women are inherently more skilled at language acquisition than men, or whether the

expectation for them to act as nurturers involve representing male husbands, fathers, siblings and husbands when they are unable to do so.

Cultural differences between providers and their populations served proved to be just as much of a barrier as language in healthcare. Customs, traditions and beliefs held by patients do not always correlate with those who treat them. This was shown to be even more of a concern with mental health, a field in which understanding a patient's mindset is considered crucial for quality care. Specialty fields of medicine overall were found to have a shortage of Spanish-speaking and culturally-aware physicians. Different solutions to this predicament were suggested by directors of health centers, clients, and medical professionals. However, there was no consensus from either patients or providers as to who is most responsible or what should be done in order to make significant progress. This further reveals the complexity of the debate and shows that language lines and interpreters are merely one step in ensuring culturally and linguistically appropriate care

It is clear that language and cultural barriers lead to difficulty for Spanish-speaking populations receiving getting medical treatment in the United States. Still, it is valuable to note that this is only one factor that contributes to an overall disparity in healthcare. The populations who do not have the resources or time to learn English are also most likely to encounter racial, class and cultural discrimination. Such barriers, however, can only be broken down when they are addressed and steps are taken to challenge them. In order to overcome obstacles and makes steps towards a more inclusive society, one must recognize issues that need to be confronted. Communication in healthcare is one such example of an issue to be faced – regardless of which language is used to speak about it.

EPILOGUE

Amidst a swarm of nurses, Doctors, aids and patients, I stand watching the chaos unfold before my eyes. It is early afternoon, also known as rush hour in the emergency department. I file folders, carry trays and answer phones – anything within my power as a volunteer. But what I really want to do is assist the patients lying on the highly-starched sheets afforded by the hospital. I generally have little-to-no contact with the patients, aside from the infrequent requests for water or blankets. I am instructed not to interfere with the management of those being treated; my job is to observe and assist with menial tasks at hand. This is why I come to be surprised when I am asked to communicate between a physician and his client.

“Who here speaks Spanish?” the Doctor says, setting down his clipboard with a list of names and languages that cover the top page. “I can’t find anyone here who is put down as a translator for the hospital.

“She does,” says the secretary, pointing to me. I had just talked to her about my plans to go abroad to a Spanish-speaking country. “Use the volunteer.”

“Well, can you do it or not?” asks the Doctor.

“I know Spanish, sure... but I don’t know if I’ll be able to say everything -- ”

“ -- Can you do it or not?” interjects the Doctor.

“Umm sure, I’ll try.” Standing up, I silently practice and conjugate different verbs in my mind as I follow the Doctor to Bed#5.

Upon reaching our destination, we pull back the curtain to find the elderly man who has hypertension and is at risk for a stroke. The Doctor asks me to inform the patient about his medication, and to set up an appointment for him get a check-up. I go over the

barely legible handwriting on the prescription, and tell the man the name of his medication. He glances over at the small piece of paper and asks if he has to take it eleven times a week. Thinking that such a dosage was strange for his condition, I look at it again and see that it says to take one pill every seven days. After thinking about it for a moment, I realized that he was confusing the word for “eleven” in Spanish (*once*) with once, a mistake that would have been easy to make and very detrimental to his health.

The Doctor looked anxious to understand our exchange, and I told him about the confusion. He nodded his head in agreement, as if to say that he was all too familiar with such misunderstandings. I return to the patient, and we review the instructions one more time, after which point we set up a date for his next appointment.

The man turns to the Doctor and thanks him for his time, nodding in gratitude. He then faces me and shakes my hand warmly. “Gracias señorita. Que Dios te bendiga.”

“Igualmente, señor,” I say with a smile. As I watch him leave the emergency department, the automatic doors slide open and close, under the bright red exit lights and the sign next to it marked “SALIDA.”

EPÍLOGO

En medio de una multitud de enfermeras, ayudantes y pacientes, veo el caos ocurriendo delante de mí. Es el comienzo de la tarde, también conocido como la hora de tráfico en la sala de emergencia. Arreglo archivos, cargo bandejas y contesto teléfonos – algo que puedo hacer como una voluntaria. Pero lo que quisiera hacer es asistir a los pacientes, aquellos que están acostados en las sábanas de almidón del hospital. En verdad no tengo mucho contacto con los pacientes, aparte de los pedidos infrecuentes de agua o matas. Me mandan a no interferir con el gerente de aquellos que están siendo tratados; mi trabajo es observar y asistir con tareas menéales. Ésta es la razón por la cual estoy sorprendida cuando me preguntan que si me puedo comunicar por un médico y su cliente

“Who here speaks Spanish?” dice el médico, estableciendo su sujetapapeles con una lista de nombres y idiomas que cubren la página superior. “I can’t find anyone here who is put down as a translator for the hospital.”

“She does,” dice la secretaria, señalando hacia mí. Acabo de hablar con ella sobre mis planes para ir al extranjero a un país Hispano. “Use the volunteer.”

“Well, can you do it or not?” pregunta el médico.

“I know Spanish, sure... but I don’t know if I’ll be able to say everything -- ”

“ -- Can you do it or not?” interrumpe el médico.

“Umm sure, I’ll try.” Levantándome, practico y conjugar los verbos diferentes en mi mente mientras que sigo al médico a la Cama #5.

Al llegar a nuestro destino, apartamos la cortina para encontrar un hombre mayor que tiene hipertensión y está a riesgo de un derrame. El médico me pregunta que informe al paciente sobre su medicación y decirle que haga una cita para que tenga un chequeo.

Paso la escritura que casi no puedo leer en la receta, y le digo al hombre el nombre de su medicamento. Él echa un vistazo al pedazo del papel pequeño y me pregunta si tiene que tomar las pastillas once veces a la semana. Pensando que tal cantidad parece extraña para su condición, yo la miro de nuevo y veo que dice tomar una píldora cada siete días. Después de pensar por un momento, me doy cuenta que él confundió la palabra “once” en español con “once” en inglés, una equivocación que habría sido fácil de hacer y muy fatal a su salud.

El médico se ve impaciente por entender nuestro intercambio, y le explico toda de la confusión. Él asiente la cabeza en el acuerdo, indicándome que él ya ha visto tales malentendidos. Vuelvo al paciente, nos repasamos las instrucciones una vez más. Después, le ayudo a planear una fecha para su cita siguiente.

El hombre da vuelta al médico y le agradece por su tiempo, asintiendo la cabeza en gratitud. Él entonces me hace frente y me da la mano con gusto. “Gracias señorita. Que Díos te bendiga.”

“Igualmente, señor,” digo con una sonrisa. Mientras le veo saliendo la sala de emergencia, las puertas automáticas se abren y se cierran, bajo luces rojas brillantes y la muestra al lado de ellas marcado “SALIDA.”

APPENDICES



APÉNDICES

LA ENCUESTA

THE SURVEY

Favor marca las opciones que son puestos abajo e escribe en los blancos dados
 Please mark the options that are written below and write in the blanks provided

1. ¿Que idioma habla Usted en la infancia?

What is your native language?

- a. *Español* b. *Inglés* c. *Otros:* _____
 Spanish English Others

2. ¿Habla Usted el inglés?

Do you speak English?

- a. *Sí* b. *No*
 Yes No

2.1 Si la respuesta es sí ¿Qué grado de practica tiene?

If so, how proficient are you?

- a. *Hablo* b. *Escribo* c. *Leo* d. *Hago a,b,c*
 I speak I write I read I do a,b,c

2.2 Si la respuesta es no ¿Hay alguna razón en particular?

If no, is there a particular reason?

- a. *Sí* b. *No* *La razon:* _____
 Yes No The reason: _____

3. ¿Ha sido difícil aprender otro idioma?

Has it been difficult learning another language?

- a. *Sí* b. *No*
 Yes No

3.1 ¿Le parece difícil llegar a ser un inglés hablante?

Do you consider it difficult to become fluent in English?

- a. *Sí* b. *No*
 Yes No

3.2 ¿Porqué sí o porqué no?

Why or why not? _____

4. ¿Usted suele ir a una clínica privada o una clinica pública?

Do you go often go to a private practice or clinic?

- a. *Privada* b. *Pública*
 a. Private b. Public

4.1 ¿Con qué frecuencia Usted va al médico?

How often do you go to the Doctor?

- a. *1-2 veces cada semana* b. *1-2 veces cada mes*
 1-2 times every week 1-2 times every month
 c. *1-2 veces cada seis meses* d. *1-2 veces cada año*
 1-2 times every six months 1-2 times every year

5. ¿Todos de los médicos que Usted ha conocido hablan español?

Have all of the Doctors that you have known speak Spanish?

- a. *Sí* b. *No*
 Yes No

5.1 Si la respuesta es sí ¿Cuál es su nivel en general?

If the answer is yes, what is their level, in general?

- a. *Avancado* b. *Intermedio* c. *Bajo*
 Advanced Intermediate Low

6. ¿Ha habido algún tipo de barrera entre Usted y su médico por el idioma?

Has there been a type of language barrier between you and your Doctor?

- a. *Sí* b. *No*
 Yes No

7. *¿Se ha sentido alguna vez incapaz de comunicar sus necesidades o dudas con su médico debido al idioma?* a. Sí b. No
Have you ever felt unable to communicate your needs and concerns with the physician due to a language barrier? Yes No
8. *¿Se ha sentido alguna vez insatisfecho con el cuidado médico que ha recibido debido a los problemas con el idioma?* a. Sí b. No
Did you ever feel unsatisfied with the medical care you received due to problems with a language barrier? Yes No
9. *¿Usted cree que hay otros factores que causa problemas de comunicación entre pacientes y médicos aparte del idioma?* a. Sí b. No
Do you believe that there are factors other than language that cause communication problems between patients and Doctors? Yes No
- 9.1 *Si la respuesta es sí, escribe ejemplos:* _____
If the answer is yes, write examples: _____
10. *¿Cuál cree Usted podría haber sido una solución para aquellos que tiene este problema con comunicación en salud médica?*
What do you think could be a possible solution for those who have problems with communication in healthcare?
a. *El paciente aprende el inglés* b. *El médico aprende el español*
The patient learns English The Doctor learns Spanish
c. *Proviene un intérprete* d. *Otro* _____
Provide an interpreter Other _____
11. *¿Qué tipos de resultados Usted piensa que pueda ocurrir en caso de que su solución se tome en consideración?* _____
What do you think are possible outcomes that could happen in the event that your solution is taken into consideration? _____
12. *¿Cuál es su género?:* _____
What is your sex? _____
13. *¿De dónde es Usted?* _____
Where are you from? _____
14. *¿Cuántos años tiene?* a. 10-19 b. 20-29 c. 30-39 d. 40-49 e. 50-59 f. ≥ 60
How old are you?
15. *¿Por cuántos años ha estado viviendo en los Estados Unidos?* _____
How long have you been living in the United States? _____

INFORMED CONSENT
CONSENTIMIENTO Y INFORMACIÓN

I agree to participate in the research of Jessica Sarah Bayner about communication in medicine concerning the relationships between physicians and patients.

Acuerdo participar en la investigación de Jessica Sarah Bayner sobre la comunicación en medicina concerniente a las relaciones entre médicos y pacientes.

I understand that the research involves answering questions and talking about my experiences and my knowledge of health care.

Entiendo que esta investigación implica responder a preguntas y hablar sobre mis experiencias y mi conocimiento del cuidado médico.

I understand that the benefits of this research is not known, and have been told that I may learn more about the impact of communication in medicine.

Entiendo que los beneficios de esta investigación no son conocidos, y se me ha notificado que podría aprender más acerca del impacto de la comunicación en medicina.

I understand that research taking place in Guadalajara and New York will last one month while the researcher acquires knowledge about the conditions of the place with which I am associated. I understand that research taking place in Connecticut will last for one semester (about four months).

Entiendo que esta investigación en Guadalajara y Nueva York durará un mes mientras la investigadora adquiera conocimiento sobre las condiciones del lugar con el que estoy asociado/a. Entiendo que la investigación en Connecticut durará un semestre (aproximadamente cuatro meses).

I have been told that there are no risks or physical harm from which the participants will suffer as a result of this research.

Se me ha notificado que no hay riesgos ni daños físicos que los participantes vayan a sufrir a causa de esta investigación.

I have been told that Jessica Sarah Bayner can be contacted at jsbay@conncoll.edu

Se me ha notificado que Jessica Sarah Bayner puede ser contactada a través de jsbay@conncoll.edu

I understand that I can decline to respond to any questions that I see fit, and that you can withdraw myself from the research without penalty at any time.

Entiendo que no estoy obligado/a responder a cualquiera de las preguntas, y que me puedo retirar de la investigación sin penalización en cualquier momento.

I understand that all of the information will be identified by a code number, not by my name.

Entiendo que todo de la información será identificado por un número de código, y NO por mi nombre.

I have been advised that I can contact the researcher who will answer any questions that I may have about the purposes and procedures of the research.

Se me ha notificado que puedo contactar la investigadora la cual responderá cualquier pregunta que yo pueda tener sobre los propósitos y procedimientos del estudio.

I understand that this research is not to obtain information about specific individuals and that my answers will be combined with data from the other participants.

Entiendo que esta investigación no es para obtener información sobre un individuo en particular y que mis respuestas van a ser combinadas con los datos de los otros participantes.

I am in agreement with the publication of the study as long as the identity of all of the participants will be protected.

Estoy de acuerdo con la publicación del estudio siempre y cuando la identidad de todos los participantes sea protegida.

The research has been approved by the “Human Subjects Institutional Review Board” (IRB) of Connecticut College. You may contact the IRB chair, Ann Devlin, at ann.devlin@conncoll.edu

La investigación ha sido aprobado por <<The Human Subjects Institutional Review Board>> (IRB) de Connecticut College. Usted pueda contactar la Directora de la Junta, Ann Devlin, a ann.devlin@conncoll.edu

Participant's Signature*
*Firma del participante**

Date
Fecha

*If you are younger than eighteen years old, please obtain the signature of your parent with the parental consent form.

**Si eres más joven de dieciocho años, por favor obtiene la firma de su padre con otra forma de permiso paterno.*

PARENTAL CONSENT
PERMISO PATERNO

I agree to participate in the research of Jessica Sarah Bayner about communication in medicine concerning the relationships between physicians and patients.

Acuerdo participaer en la investigación de Jessica Sarah Bayner sobre la comunicación en medicina concerniente a las relaciones entre médicos y pacientes.

I understand that the research involves my child answering questions and talking about his/her experiences and his/her knowledge of health care.

Entiendo que esta investigación implica mi hijo responder a preguntas y hablar sobre sus experiencias y su conocimiento del cuidado médico.

I understand that the benefits of this research are not known, and have been told that my child and I may learn more about the impact of communication in medicine.

Entiendo que los beneficios de esta investigación no son conocidos, y se me ha notificado que my hijo y yo podríamos aprender más acerca del impacto de la comunicación en medicina.

I understand that research taking place in Guadalajara and New York will last one month while the researcher acquires knowledge about the conditions of the place with which I am associated. I understand that research taking place in Connecticut will last for one semester (about four months).

Entiendo que esta investigación en Guadalajara y Nueva York durará un mes mientras la investigadora adquiera conocimiento sobre las condiciones del lugar con el que estoy asociado/a. Entiendo que la investigación en Connecticut durará un semestre (aproximadamente cuatro meses).

I have been told that there are no risks or physical harm from which the participants will suffer as a result of this research.

Se me ha notificado que no hay riesgos ni daños físicos que los participantes vayan a sufrir a causa de esta investigación.

I have been told that Jessica Sarah Bayner can be contacted at jsbay@conncoll.edu

Se me ha notificado que Jessica Sarah Bayner puede ser contactada a través de jsbay@conncoll.edu

I understand that my child can decline to respond to any questions that s/he sees fit, and that s/he can withdraw his/herself from the research without penalty at any time.

Entiendo que mi hijo no está obligado/a responder a cualquiera de las preguntas, y que se puede retirar de la investigación sin penalización en cualquier momento.

I understand that all of the information will be identified by a code number, not by my child's name.

Entiendo que todo de la información será identificado por un número de código, y NO por el nombre de mi hijo.

I have been advised that my child and I can contact the researcher who will answer any questions that we may have about the purposes and procedures of the research.

Se me ha notificado que mi hijo y yo podemos contactar la investigadora la cual responderá cualquier pregunta que podamos tener sobre los propósitos y procedimientos del estudio.

I understand that this research is not to obtain information about specific individuals and that my child's answers will be combined with data from the other participants.

Entiendo que esta investigación no es para obtener información sobre un individuo en particular y que las respuestas de mi hijo van a ser combinadas con los datos de los otros participantes.

I am in agreement with the publication of the study as long as the identity of all of the participants will be protected.

Estoy de acuerdo con la publicación del estudio siempre y cuando la identidad de todos los participantes sea protegida.

The research has been approved by the "Human Subjects Institutional Review Board" (IRB) of Connecticut College. You may contact the IRB chair, Ann Devlin, at ann.devlin@conncoll.edu

La investigación ha sido aprobado por <<The Human Subjects Institutional Review Board>> (IRB) de Connecticut College. Usted pueda contactar la Directora de la Junta, Ann Devlin, t ann.devlin@conncoll.edu

Parent's Signature
Firma del padre

Date
Fecha

DEBRIEFING FORM

RESUMEN DE LA INVESTIGACIÓN

I would like to thank you for being a part of my research dealing with healthcare and communication. In this study I am analyzing the impact that language, specifically Spanish has had on the quality of healthcare between patients and physicians. In addition the patients in a clinic in Guadalajara, Mexico, other people will be asked to express their thoughts on the subject. Such participants include staff and patients in a private practice in Long Island, NY, as well as the Community Health Center in New London, CT. It has been found that many Hispanics are unhappy with the medical care they receive especially those who are not proficient in English. There are also not enough translators or different ways of adequately communicating to fully overcome the language barrier. While there has been research done on bilingualism and healthcare, the approach to this study and the sites that are included in this research have not been dealt with before, to my knowledge.

Me gustaría darle mis gracias por formar parte de mi investigación sobre el cuidado de la salud y la comunicación. En este estudio, analizo como el lenguaje, específicamente el español, ha impactado la calidad del cuidado de la salud entre pacientes y médicos. Aparte de los pacientes en una clínica en Guadalajara, Mexico, se les pedirá a otras personas expresar sus opiniones sobre el asunto. Estos participantes incluyen el personal y los pacientes de una clínica privada en Long Island, NY, así como el centro de la salud de la comunidad en New London, CT. Se ha encontrado que muchos hispanos no están contentos con el cuidado médico que reciben, especialmente aquellos que no están proficientes en el inglés. No hay un número adecuado de traductores y no hay otras maneras para superar las barreras de idioma. Mientras se han hecho estudios sobre bilingüismo y el cuidado de la salud, según mi conocimiento, hasta el día de hoy ninguno poseía el enfoque de este estudio y ninguno cubre los lugares incluidos en éste.

If you want to contact me, I can be reached at jsbay@conncoll.edu. If you have any questions or concerns about this research, you may also contact Ann Devlin, the IRB chair, at ann.devlin@conncoll.edu.

Si quieres hablar conmigo, yo puedo ser contactada a través de jsbay@conncoll.edu. Si tengas algunas preguntas o dudas sobre este investigación, pueda contactar la Directora del IRB Ann Devlin a través de ann.devlin@conncoll.edu.

Listed below are two sources you may want to consult to learn more about this topic:
Para aprender más sobre este tema se puede consultar las siguientes publicaciones :

De Paula, T., Lagana, K., & Gonzalez-Ramirez, L. (1996). Mexican Americans. In J. G. Lipson, S. L. Dibble, & P. A. Minarik (Eds.). *Culture & nursing care* (pp. 203-221). San Francisco: UCSF Nursing Press.

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E

DVD SLIDES
DIPOSITIVAS DEL DVD



INFORMACIÓN PERSONAL PERSONAL INFORMATION

Nombre
Dirección
Apellido
Casado(a)/soltero(a)
Número de teléfono



Name
Address
Last Name
Married/Single
Telephone number

¿Cuál es su idioma preferido?

¿Tiene seguro?

¿Ha sido vacunado/a para __?



What is your preferred language?

Do you have insurance?

Have you been vaccinated for __?

PREGUNTAS QUESTIONS

¿Por qué viene a consulta?

¿Cómo se siente?

¿Tiene fiebre?

¿Dónde le duele?

¿Orina Usted con frecuencia?

¿Tiene Usted los tobillos hinchados?

Why did you come for a consultation?

How you do feel?

Do you have a fever?

Where does it hurt?

Do you urinate frequently?

Do you have swollen ankles?



EXPRESIONES EXPRESSIONS



Estoy enfermo/a
I am sick

Estoy resfriado/a
I have a cold



Necesito una radiografía de:

la cabeza
la rodilla
el pecho
la mano



I need an X-ray of:

my head
my knee
my chest
my hand

Me duele _____:

el estómago
el cuello
la garganta

My _____ hurts:

stomach
neck
throat

PREGUNTAS QUESTIONS

¿Cuántas veces al día cepilla Usted los dientes?
How many times a day do you brush your teeth?



¿Que pasta dentífrica usa Usted?
What type of toothpaste do you use?



¿Le duele cuando toma algo muy frío?

Are you in pain when you drink something very cold?



¿Ha tenido una limpieza?
Have you had a cleaning?

¿Usted usa seda dental?
Do you use dental floss?



EXPRESIONES EXPRESSIONS

Enjuégese con agua y sal



Rinse with saltwater

Abra la boca



Open your mouth

Cepílese los dientes



Brush your teeth

Necesita empastar su diente



You need to get your tooth filled

CLASES DE DIENTES TYPES OF TEETH

el canino
canine



la muela de juicio
wisdom tooth



el incisivo
incisor



la muela
molar



VOCABULARIO GENERAL GENERAL VOCABULARY

<i>aliento</i>	breath
<i>la boca</i>	mouth
<i>la carie</i>	cavity
<i>la corona</i>	crown
<i>el canal en la raíz</i>	root canal
<i>la placa</i>	plaque
<i>la encía</i>	gums
<i>dormido</i>	numb
<i>novocaina</i>	novacaine



PREGUNTAS QUESTIONS



¿Algo traumático le ha ocurrido recientemente?
Did something traumatic happen to you recently?

¿Hay algo específico que le causa sus síntomas?
Does something specific trigger your symptoms?

¿Alguna vez se ha hecho daño?
Have you ever caused harm to yourself?

¿Ha tenido pensamientos sobre suicidio?
Have you had thoughts about suicide?

¿Ve o escuche a alguien que nadie de su alrededor puede ver ni escuchar?
Do you see or hear anyone that no one around you can see or hear?

EXPRESIONES EXPRESSIONS

No he dormido desde _____
I have not slept since _____

Me siento fuera de onda
I feel out of it

Me pierdo en mis propios pensamientos
I get lost in my own thoughts



No me siento como mi mismo/a
I am not feeling like myself

Muchas ideas se agolpaban en mi cabeza
Many ideas race through my head

Nada me satisface ni me da placer
Nothing satisfies me or gives me pleasure

SÍNTOMAS DE DEPRESIÓN SYMPTOMS OF DEPRESSION

Me siento:

- *Culpable*
- *Irritable*
- *Agotado/a*
- *Decaído/a*
- *Cansado/a*
- *Desesperado/a*
- *Ansioso/a*
- *Tenso/a*
- *Acabado/a*



I feel:

- Guilty
- Irritable
- Exhausted
- Down
- Tired
- Hopeless
- Anxious
- Tense
- Drained

EMOCIONES EMOTIONS



Intranquilidad

Restlessness

Sentimientos de

Esperanza

Hope

Lástima

Sympathy

Emoción

Excitement

Felicidad

Happiness



EXPRESIONES EXPRESSIONS

A mí no me cae bien

Me siento un dolor agudo/sordo



I feel sharp/dull pain



It doesn't sit well with me

Soy alérgico/a a los antibióticos



I am allergic to antibiotics

Necesito algo para mi hipertensión



I need something for my hypertension

No puedo mezclar esos medicamentos



I cannot mix those medications

INSTRUCCIONES INSTRUCTIONS

Tome la medicina:

- *antes de cada comida*
- *cada seis/ocho horas*
- *entre comidas*
- *en ayunas*
- *al acostarse*



Take the medicine:

- before each meal
- every six/eight hours
- between meals
- before eating
- before bedtime

CREADO POR:

CREATED BY:

Jessica Sarah Bayner

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Connecticut College

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